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Experiences of Aggression and Violence Across Dementia and Adult Acute Psychiatric Facilities.

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This thesis is submitted in partial fulfilment of the requirements for the
degree of Doctorate in Clinical Psychology.

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List of Abbreviations

BPS	British Psychological Society
DOH	Department of Health
ICN	International Council of Nurses
ILO	International Labour Office
IPA	Interpretative Phenomenological Analysis
MAPA	Management of Actual and Potential Aggression
NHS	National Health Service
NMHDU	National Mental Health Development Unit
PICU	Psychiatric Intensive Care Unit
PRISMA	Preferred Reporting Items for Systematic Reviews and Meta-analyses
PSI	Public Services International
QAF	Quality Assessment Framework
UK	United Kingdom
USA	United States of America
WHO	World Health Organisation

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Declaration

I declare that this thesis has not been submitted for any other degree or to any other institution. I declare that, aside from the collaborative work undertaken with my research supervision team, this work is my own. This thesis was completed under the academic supervision of Dr Helen Liebling (Clinical Psychologist, Coventry University) and Dr Anthony Colombo (Senior Lecturer, Coventry University) and under the clinical supervision of Matthew Wilcockson (Psychological Therapist). Initial ideas and the formulation of my research proposal were supervised by Dr Carolyn Gordon (Clinical Psychologist, Coventry University) and Dr Michelle Webster (Clinical Psychologist). The literature review has been written in preparation for submission to the Journal Dementia (Power, Colombo & Liebling). The empirical paper has been written in preparation for submission to the Journal Issues in Mental Health Nursing (Power, Liebling, Colombo & Wilcockson).

Summary

This thesis explores care staff and nurses' experiences of aggression and violence whilst working in dementia and adult acute psychiatric facilities. Chapter one presents a systematic literature review of studies based on the perceptions and impact of aggression from patients with dementia, adopting a care staff perspective. The findings highlighted the subjective experiences of aggression, care staff perceptions of its causes and the physical and psychological impact which aggression had on care staff. A key finding was that care staff perceptions of aggression and its impact influenced patient care and the reporting of aggression. The chapter discusses key implications for practice and policy and identifies recommendations for future research.

Chapter two consists of an empirical study exploring nurses' lived experiences of violence from patients whilst working on adult acute psychiatric facilities. Eight nurses were recruited from two hospital sites and completed semi-structured interviews. Analysis of the data revealed the personal perceptions of violence and its causes and the psychological, physical, occupational and relational impact that violence had on the nurses. All nurses employed individual and group survival strategies to help manage their experiences of violence and its impact. Implications for clinical practice and policy and recommendations for future research are discussed.

Chapter three presents a reflective account of my research journey throughout training to be a Clinical Psychologist. I use a reflexive stance to explore the development of my research interest, the meaning of violence and to discuss my own responses to the nurses' experiences. The paper also explores how I managed different roles during the research process and how I have developed as a clinician and researcher.

Chapter 1: Systematic Literature Review

Title: Perceptions and Impact of Aggressive Behaviour from Dementia Patients: A Systematic Review of the Literature Adopting a Care Staff Perspective.

Written in preparation for submission to the Journal Dementia (See Appendix A for author guidelines). The abstract and overall word count shall be reduced to the required length before submitting to this journal.

Overall chapter word count (excluding tables, figures and references):

7, 535 words.

Abstract

Aims: This systematic review of the literature adopted a care staff perspective. The aim was to make sense of care staff' perceptions of aggression from dementia patients and what impact it had on care staff' wellbeing and working relationships.

Method: The review was conducted during April 2016 using PsycInfo, Web of Science, Scopus and Cumulative Index to Nursing and Allied Health Literature (CINAHL). Eighteen studies were identified through this systematic process. These studies met the inclusion criteria and were considered of good quality after being assessed by a Quality Assessment Framework (QAF).

Findings: The main findings highlighted three principal themes: 1) aggression was a subjective term, defined differently by care staff. Care staff considered a variety of factors which may have contributed to causing aggression from patients, demonstrating the use of a person-centred paradigm when viewing aggressive conduct. 2) The extent of physical injury and psychological trauma was revealed. 3) Care staff perceptions of aggression and the impact of it affected care approaches utilised with patients and the reporting of aggression.

Conclusions: The practice implications are that formal support structures, standardised reporting procedures, education and training are essential in ensuring that aggression is understood, reported, managed appropriately and that care staff feel supported. The development of future research in this area requires a focus on: exploring the views of wider professional groups and relatives of patients, exploration of other behavioural and psychological symptoms and further research into sexual behaviour from patients with dementia.

Keywords: aggression, dementia, review, staff

1.0 Introduction

1.1 Background

Dementia is a generic term used to describe a decline in mental ability, including memory and thinking skills, which is severe enough to interfere with an individual's every day functioning (Shih, Concannon, Liu & Friedman, 2014). In 2015, 46.8 million people had dementia worldwide (Prince et al., 2015). Current statistics suggest that by the year 2050, this figure will increase to 131.5 million people (Prince et al., 2015).

One of the consequences of dementia can be displays of aggressive behaviour (Shih et al., 2014). Research has shown that at least 86% of patients with dementia experience behavioural and psychological problems, including aggression (Duxbury, Pulsford, Hadi & Sykes, 2013). One reason for this aggression is that as a person's cognitions begin to deteriorate and competing stimuli and demands in the environment become increasingly difficult to manage (Scott, Ryan, James & Mitchell, 2011). The individual's problem solving skills and communication skills may begin to decline; this can lead to frustration, which may be expressed as aggression (Scott et al., 2011). Overall, the literature suggests that these aggressive behaviours may include any physical or sexual acts or gestures or any verbal, emotional or psychological abuse in which care staff feel threatened (Scott et al., 2011). The literature uses different terms to describe aggression, such as violence, abuse, challenging behaviour and behavioural disturbance (Scott et al., 2011); however, for the purpose of this systematic literature review, the term aggression was used throughout the article for consistency.

Direct care staff working with those on a daily basis who have dementia include: support workers, nursing assistants and nurses. Studies have shown that direct care staff are at the highest risk of being subjected to aggression from patients with dementia, as they spend the most time directly caring for the patient (Ko et al., 2012; Morgan et al., 2008). For example, a survey conducted in the UK found that 72.9% of direct care staff reported that they had been subjected to aggressive conduct from patients in care settings (Berry, 2014).

Research has shown that the ways in which care staff perceive aggression from patients is closely related to the ways in which aggressive events are managed and the quality of care which patients receive (Duxbury et al., 2013; Pulsford, Duxbury & Hadi, 2011). Additionally, aggression can have a serious psychological and physical impact on staff, which can also influence patient care and staff practice (Scott, et al., 2011).

1.2 Existing Literature Review

Scott, Ryan, James and Mitchell (2010) completed a literature review into the perceptions and implications of aggression on care staff working in residential dementia care settings. This review found that care staff varied in terms of their understanding of why patients with dementia were aggressive towards them; some viewed aggression as intentional and as a personal attack, whereas others attributed aggression to the dementia disease (Astrom et al., 2004; Middleton, Stewart & Richardson, 1999). Care staff generally did not consider whether their own behaviour or interactions contributed towards causing aggression from the patient (Middleton et al., 1999). This suggested that a lack of knowledge about the dementia

condition and a lack of self-awareness resulted in a limited understanding of the reasons why patients could become aggressive.

The results suggested that aggression did have an impact on care staff: a quarter of care staff experienced symptoms of burnout, such as exhaustion (Evers, Tomic & Brouwers, 2002) and most staff felt fearful that they could be assaulted again or that they would be blamed for the assault against them if they reported it (Menckel & Viitasara, 2002).

The findings also indicated that perceptions of aggression did not influence how care staff cared for patients who had been aggressive (Todd & Watts, 2005). Contrary to this, Evers et al. (2002) found that burnout caused care staff to emotionally and physically distance themselves from patients, reducing quality of care for patients.

Despite these important findings, Scott et al. (2010) concluded that this area had received considerably less attention than other healthcare departments, such as accident and emergency and general healthcare.

1.3 Rationale for the Current Systematic Literature Review

The earlier review by Scott et al. (2010) has two key strengths. Firstly, the review synthesises important findings which were consistent across cultures, implying that this was a cross-culturally relevant phenomenon. Secondly, the review has important recommendations, such as the need for further training and education for care staff in order to enhance their understanding of aggression, reduce its psychological impact and to improve the quality of care of patients.

There are, however, three important limitations to this review. Firstly, the search terms are limited to 'perceptions' and 'psychological trauma'. This may exclude relevant papers which focus on care staff 'views', 'attitudes', 'beliefs', 'responses' and the 'impact', 'influence' and 'consequences' of 'aggression'. As such, this may limit our understanding of all care staff perceptions and responses in this area.

Secondly, the review by Scott et al. (2010) focuses on care staff working in residential units for dementia. Hospital settings were excluded from this review, therefore the articles highlighted may not be relevant across the range of health care settings. Research suggests that care staff working in hospital settings for those with dementia are frequently subjected to aggression from patients (Ko et al., 2012), therefore inclusion of these studies is important (Ko et al., 2012).

Thirdly, the existing review briefly mentioned that perceptions did not influence care staff practice, but that the impact of aggression did; however, this was not included as an objective of the review and was not discussed in any detail. Determining their influence is vital in order to ensure good practice and quality patient care (Duxbury et al., 2013).

This systematic review aimed to address these shortcomings in a number of ways:

Firstly, by including a broader range of search terms and terms with a more neutral/generic connection with the perceptions and impact of aggression. Secondly, by including a range of community and hospital care settings in order to expand our understanding across settings. Thirdly, by fully considering the connection between care staff perceptions and impact of patient aggression on clinical practice.

Finally, by reviewing the wider literature on care staff attitudes towards patient aggression (Nakahira, Moyle, Creed & Hitomi, 2008) and the extent of its' impact (Scott et al., 2011) that has emerged since the previous review by Scott et al. (2010).

From accessing this broader set of literature, this systematic review aimed to explore the following questions:

1. What are care staff perceptions of aggression from dementia patients?
2. What is the impact of aggression on care staff from dementia patients?
3. How do care staff perceptions of aggression from dementia patients and its impact affect practice?

2.0 Method

2.1 Overview

A systematic search of the literature was carried out during April 2016. The search for literature spanned four key disciplines: medical, nursing, applied health and psychology and included the following databases: PsycINFO, Web of Science, Scopus and Cumulative Index to Nursing and Allied Health Literature (CINAHL). In addition, a manual search of reference lists from the relevant papers was conducted. Studies obtained from these searches were added to RefWorks in order to be screened for inclusion (ProQuest LLC., 2016). Google scholar and the Department of Health website were searched in an attempt to include papers from the grey literature.

2.2 Search Terms and Strategy

The relevant terms used in the previous review by Scott et al. (2010) were included, alongside additional variations of terms which were considered to broaden the search. Table 1 highlights the key search terms used, the variations of these and the location within the articles in which the search took place.

Key search terms were truncated if necessary using * in order to yield variations of words. Wild cards, such as *, \$ and #, were used to indicate variations in spelling of words according to either English or American language. Speech marks, “” were used in order to locate a particular phrase. Key search terms were combined using the Boolean operator AND and the variations of key search terms were combined using the Boolean operator OR. For example, the following was conducted: dementia AND aggress* (synonyms included here) AND perce* OR impact (synonyms included here).

Table 1: Search Terms

Key Search Term	Variation	Location in PsycINFO	Location in Scopus	Location in Web of science	Location in CINAHL
Dementia	No variation.	Title Abstract	Title Abstract	Topic: title, abstract, main text.	Title Abstract
Aggression	Violen* Abus* “Challenging behavio\$r*” Behavio\$ral “Behavio\$r* of concern” “Combative behavio\$r*” “Behavio\$r* that challenge”.	Title Abstract	Title Abstract	Topic: title, abstract, main text	Title Abstract
Perception Impact	View* Belief* Perspective* Attitude* Experience* Opinion* Attribut* Apprais* Consequence* Effect* Influence* React* Respon*	Title Abstract	Title Abstract	Topic: title, abstract, main text	Title Abstract
Care staff	Staff "care worker*" “care assistant*” "healthcare personnel" practitioner* "professional caregiver*" "formal caregiver*" "healthcare worker*" nurse* "assistant nurse*" “nurs* assistant*” "nurs* aide*" "support worker*" "healthcare assistant*”.	Title Abstract	Title Abstract	Topic: title, abstract, main text	Title Abstract

2.3 Inclusion and Exclusion Criteria

Table 2 below details the inclusion and exclusion criteria for this review. This review included professional care staff. Care staff must work with those who have dementia, as the study has a focus on a patient population with dementia. Care staff included anyone who was directly caring for the patient in a professional capacity and on a frequent basis; for example, nurses, nurse assistants, healthcare assistants, care workers and support workers. This group of care staff are at higher risk of experiencing aggression than other professional groups, such as psychiatry and psychology, due to the amount of contact they have with patients (Morgan et al., 2008). Studies focusing on administrative staff or purely informal carers, such as relatives, were excluded. Studies based on informal caregivers and care staff were included if results relevant to care staff were distinguishable. Studies were excluded if the type of caregiver could not be determined. Studies which were not related to perceptions and impact of aggression from a care staff perspective were excluded.

Dementia type was not specified for this review. Many types of dementia can cause behavioural disturbance, including aggression, therefore this study did not limit the type of dementia (Scott et al., 2010). Articles were excluded if they related to cognitive impairment only, as this is not a dementia (Smith & Bondi, 2013). Studies focusing on a purely aging population, or an aging population with mental illness exclusive of dementia were not included. Due to the high prevalence of patients with dementia in nursing homes (Isaksson, Graneheim & Astrom, 2009), studies based on nursing homes were included if the results were relevant to aggression and dementia.

Types of aggression were not specified for this inclusion criteria due to the broad nature of 'aggression'; therefore, any paper based on 'aggression' or an equivalent term used, such as violence or abuse, was included. Articles based on behavioural symptoms were included if results relating to aggression were distinguishable. If it was unclear as to whether results related to aggression or another behavioural symptom such as wandering, these papers were excluded.

Aggression from dementia patients can occur in any care setting (Ko et al., 2012; Scott et al., 2010). As such, this review included any locale which provide formal care such as: assisted living accommodation, community residential units, houses, and hospitals.

Both UK and international papers were included, as this area has been found to be important across cultures (Scott et al., 2010). Peer reviewed papers, both quantitative and qualitative, were included if they were written in the English language. Websites, articles and commentaries were excluded. In order to update and expand on the literature review by Scott et al. (2010) and to focus on the most up to date research since this review, articles were included between January 2005- April 2016. The past decade has seen global initiatives implemented to improve health services for those with dementia, including facilitating education and training for care staff within dementia care settings in order to increase knowledge and awareness (Department of Health, DOH, 2009; Prince et al., 2015). In order to include the most up to date literature since these developments, this review excluded articles before 2005, which was also the last paper cited in the previous review.

Table 2: Inclusion and Exclusion Criteria.

Inclusion Criteria	Exclusion Criteria
Formal professional care staff.	Administrative staff. Informal carers, such as relatives.
Any type of dementia.	Studies focusing purely on cognitive impairment or the aging population.
Aggression.	Behavioural symptoms which are not distinguishable in results section.
Setting: community or inpatient.	None excluded.
Language: Studies written in the English language.	All other languages.
Type of Article: Peer reviewed journals: including quantitative papers, qualitative papers and grey literature if relevant.	Websites, media articles, policies and commentaries.
Date: January 2005-April 2016.	Articles before 2005.
Care staff Perceptions.	Articles not related to care staff perceptions.
Impact on care staff.	Articles not related to impact on care staff.

2.4 Classification of Studies

The selection process was recorded using the ‘Preferred Reporting Items for Systematic Reviews and Meta-analyses’ (PRISMA; Liberati et al., 2009). See Figure 1 below for the PRISMA flow diagram. In total, 1,905 articles were identified; 1,707 were identified through database searches, 1 article was identified through manually searching the references of these articles and 197 were identified through other sources, such as google scholar and the department of health website. Duplicate articles were removed, leaving 1,156 articles. The titles and abstracts of these articles were screened for relevance. Of these, 1,124 were excluded due to: not meeting the review aims, not focusing on dementia or aggression or direct care staff and focusing on informal carers only. The remaining 32 articles were read to determine whether they met the inclusion criteria. Of the 32 articles that remained, 19 were retained as satisfying the inclusion criteria.

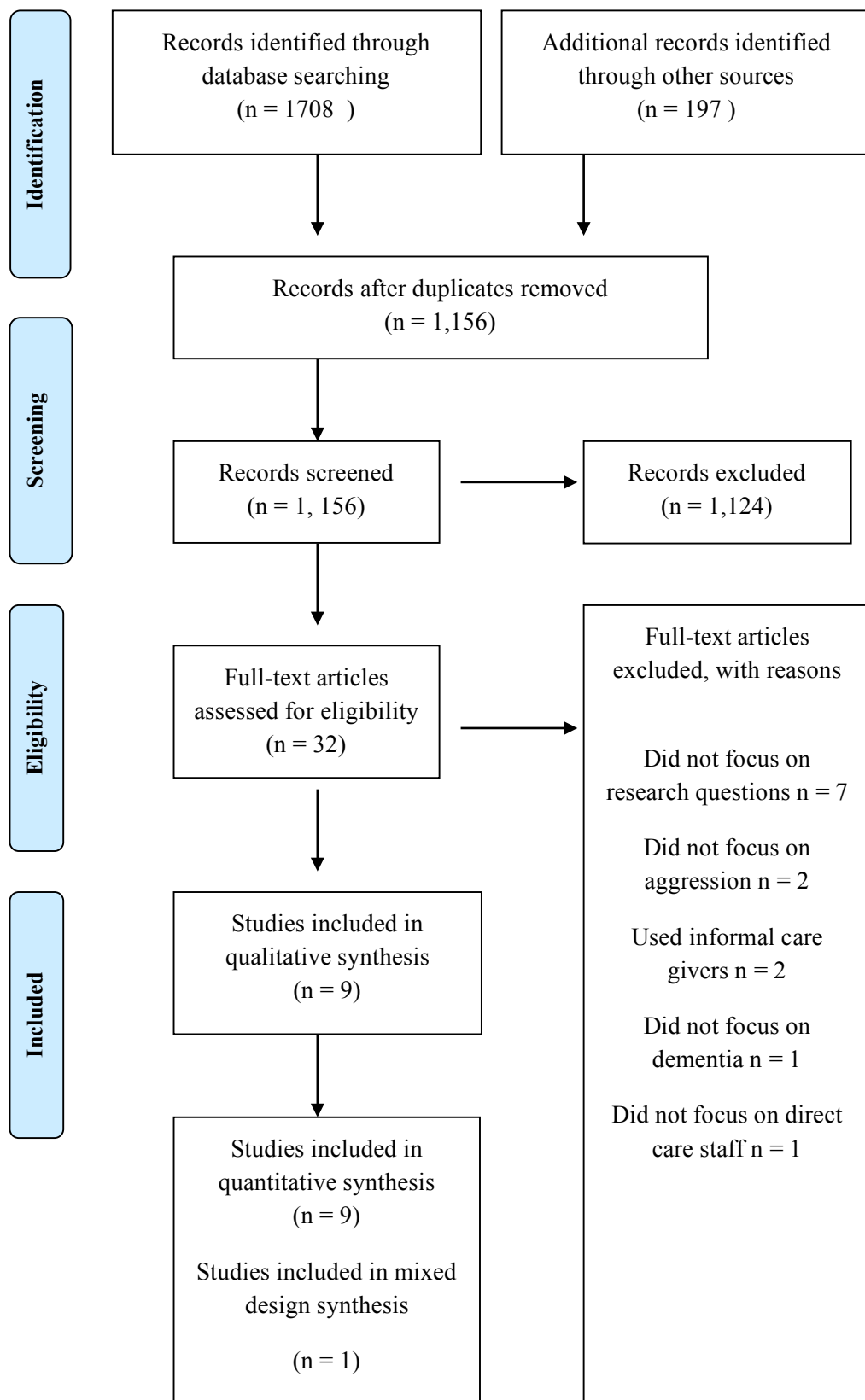


Figure 1: PRISMA Flow Diagram

2.5 Quality Assessment

A Quality Assessment framework (QAF) developed by Caldwell, Henshaw and Taylor (2005) was used in order to assess the quality of the 19 papers identified (see Appendix B for QAF criteria). This framework was selected as it is widely used in both clinical psychology and health disciplines (Caldwell, Henshaw & Taylor, 2011) and because it can assess both quantitative and qualitative papers separately. Each paper was assessed against 18 criterion and was given a score between 0-2. A score of 0 indicated that the criterion was not met, a score of 1 indicated that the criterion was partially met and a score of 2 indicated that the criterion was fully met; therefore, each paper could score a total of 36. Papers which fell below the midpoint, 18, were excluded as not meeting the necessary rigour determined by the QAF.

Another researcher rated three of the papers in order to assess inter-rater reliability. Inter-rater reliability was calculated by using Cohen's Kappa statistic as this is widely used in order to assess the inter-rater reliability between raters and is considered more accurate than calculating percentage agreements (Kline, 2005). Cohen's kappa indicated a strong correlation between the two raters, at 0.86.

2.6 Results of Quality Assessment

Eighteen out of 19 studies identified during the systematic search process gained scores over the midpoint (see Table 3 for quality percentage of each study). The paper which fell below the midpoint gained a score of 16; the paper did not have a method and analysis section, making credibility difficult to assess and there was no discussion of findings. Additionally, the paper highlighted that the results were not representative of a care staff population due to a restricted sample size. As such, this

paper was not considered to meet the necessary rigor to be included in this review. Furthermore, the study was not considered to add any further value to the review.

Overall, the papers included were considered to be of high quality; they had sufficient introductory material and the rationale for the literature review and the aims of all studies clearly stated. There were some areas of lower scoring for the quantitative studies, such as: five studies did not detail the reliability and validity of the questionnaires used in the study. It was found that only one quantitative study, by Yuki, Tachimori and Ito (2010), used a randomized sample strategy and that the majority of studies utilized convenience sampling. Although, this is considered to be reflective of the reality of recruitment during research and all but one quantitative study had large sample sizes.

Qualitative studies detailed the philosophical background for the designs chosen for each study and the method and analyses were clearly outlined and credible. Five qualitative studies were considered to have findings that could be transferred to other dementia care facilities and care staff populations and three were considered partial on this criterion.

2.7 Study Characteristics

Table 3 below details the characteristics of the studies. As you will see from Table 3, all of the authors included in this review were affiliated with both Universities and health institutions and included authors from academia and clinical practice.

Sixteen studies used sample populations outside of the United Kingdom (UK); four in Japan, three in Canada, one in Australia, five in Sweden, one in Switzerland, one in Ireland and one in Scotland. Two studies were conducted in the UK. The sample populations were obtained from various dementia care settings and can be grouped into the following settings: dementia care units in hospitals (2); community and charitable facilities (1); dementia care units within nursing homes (8); aged care assessment centres (1); general aged care units in hospital (1); general aged care in nursing homes (11); supported living accommodation (1); residential Alzheimer's care centres (1).

Nine studies used a quantitative approach, eight used a qualitative approach and one study used a mixed methods design. The quantitative studies detailed the use of a cross sectional survey design. The qualitative studies used the following designs: one study used grounded theory and seven studies used content analysis.

The sample populations across the 18 studies included: nurses, enrolled nurses, nursing aides, personal care assistants, care workers, healthcare assistants, unit managers and one study classed 0.5% of staff as 'other care workers'. Of those studies which did state the age range, this tended to be between 20 to 59 for the majority of studies; four studies had age ranges of 19 to 64, 17 to 60, 18 to 70 and 27 to 57. The sample sizes in the quantitative studies ranged from 91 to 675 care staff. One study, by Pulsford et al. (2011) used a smaller sample size of 36 staff. The sample sizes in the qualitative studies ranged from 10 to 137.

Across the studies, the main aims were to ascertain care staff perceptions or views of aggression, the impact of aggression and care staff job satisfaction in relation to having experienced aggression.

Table 3: Characteristics of Studies

Author	Aims of Study	General Research Approach	Setting and Country	Sample	Research Tools	Results relating to the research questions	Quality
Ko et al., 2012	To identify factors associated with the aggression displayed by patients who have dementia. To identify how staff feel after they have experienced aggression.	<i>Quantitative</i> Cross sectional design.	7 hospitals for patients with dementia. Japan.	242 registered nurses, 90% female, 10% male.	Questionnaire developed by the authors.	<ul style="list-style-type: none"> Aggression was attributed to personal hygiene procedures and the client's dementia disease. Care Staff felt upset by aggression and they tended to detach from the patient as a result. 	77.8%
Bostrom, Squires, Mitchell, Sales & Estabrooks, 2011	To determine the frequency of aggressive acts experienced by staff and what factors were associated with the aggressive act.	<i>Quantitative</i> Cross sectional design.	2 Residential Alzheimer's Care Centres (RACC) and 2 Secure Dementia units (SDU) 51 women worked in the RACCs and 38 in the SDU; 2 men worked in the SDUs. Canada.	73 healthcare assistants and 18 licensed practice nurses; 98% were female and 2% male.	Questionnaire survey: translating research in elder care (TREC); the Alberta Context Tool (ACT) was mostly used within this questionnaire.	<ul style="list-style-type: none"> Aggression was seen as part of the dementia disease and as such patients had not intended to be aggressive. Lack of supervisor awareness of aggression, lack of awareness of how to manage aggression and inappropriate models of managing aggression were also viewed as contributing to aggression. Inappropriate placement of patients 	86%

						was felt to cause aggression. • Staff felt that aggression was neglected by managers.	
Cubit, Farrell, Robinson & Myhill, 2007	To determine the impact of behaviours of concern on care staff.	Mixed Design: Quantitative and Qualitative: Cross sectional design. Content Analysis.	88 community and charitable facilities. Australia.	33 registered nurses 19 enrolled nurses 45 personal care assistants.	Questionnaire developed based on the reducing behaviours of concern guide (ReBOC).	• Verbal aggression caused the most disruption to the units. • Physical aggression caused the most personal distress to care staff, followed by verbal aggression. • Some care staff felt empathy towards patients who had been aggressive.	80.6%
Hirata & Harvath, 2015.	To determine whether aggressive behaviours increase burnout, intention to resign and decrease job satisfaction.	Quantitative Cross sectional design.	Dementia special care units in 10 nursing homes. Japan.	129 care workers: 88 female, 41 male.	Questionnaires and ratings of aggressive behaviour: Exposure to Disruptive Behaviour Scale (EDB); the pines burnout measure (PBM); Kahana's measure of job satisfaction.	• Care staff experienced stress and burnout due to aggressive behaviours and intention to resign due to this; however, they still reported a high job satisfaction. • Care staff appraisals of aggressive behaviour mediated the level of stress experienced.	86%

Nakahira, Moyle, Creedy & Hitomi, 2008	To determine staff attitudes towards aggression from patients with dementia.	<i>Quantitative</i> Cross sectional design.	26 % of staff worked in dementia care units, 21.8% in aged care residential units, 27.2% in aged care assessment centres, 25% worked on a gerontological unit in an acute hospital. Japan.	675 staff; registered nurses, care workers, enrolled nurses, personal care workers. 526 female, 149 males. Aged 18-70.	Questionnaire: attitudes towards aggression scale (ATAS).	<ul style="list-style-type: none"> Staff who had negative attitudes tended to use restraint and seclusion, whereas those with positive attitudes tended to listen to the patient and utilised talking techniques. Those with negative attitudes were more likely to report aggression, whereas those with positive attitudes were less likely to. 	86%
Morgan et al., 2012	To identify nurses' perceptions of combative behaviour from patients with dementia.	<i>Quantitative</i> Cross sectional design.	Working across 3 care homes and 8 special care units. Canada.	112 nursing aides; 96.3% were women, 3.7% were men. Mean age: 47.5.	Prospective event reporting diary.	<ul style="list-style-type: none"> Nursing aides reported that the dementia disease, environmental factors and personal care were the main causes for aggression from patients. Nurses reported a high level of job satisfaction due to feeling supported within their team during aggressive incidents. 	75%

Josefsson, Sonde, Robins-Whalin, 2007	To explore nurses' perceptions of violence in older care. To compare nurses' perceptions who work solely with those with dementia to nurses' who work solely with elderly patients without dementia.	<i>Quantitative</i> Cross sectional design.	33 dementia specific community units and 20 community units for elderly care. Sweden.	213 nurses; 199 were female and 14 were male. 95 nurses worked with those with dementia. 118 nurses worked in general elderly care.	Questionnaire developed within the units.	<ul style="list-style-type: none"> Both nurses working in dementia care and in elderly care experienced violence. Perceptions between dementia care and elderly care did not differ. Care staff working on dementia specific units were more likely to sustain injuries (18%) than those in general elderly care (9%) and those on dementia specific units reported feeling fearful that aggression would occur again. 	80.6%
Scott, Ryan, James & Mitchell, 2011	To examine the effects of fear on care staff psychological well-being after experiencing aggression from dementia patients.	<i>Quantitative</i> Cross sectional design.	9 care homes. Ireland.	43 registered nurses and 69 care assistants: 105 females and 7 males. Age Range: 17-60 years.	Questionnaires: the challenging behaviour fear questionnaire (CBFQ); the impact event scale (IES).	<ul style="list-style-type: none"> Staff feared for their own and colleagues' personal safety. Approximately 32% of staff experienced post-traumatic stress symptoms. 1 member of staff met the criteria for post-traumatic stress disorder (PTSD). Staff tended to 	75%

caregiver burden.							
Morgan et al., 2008	To explore nursing aide' (NA) perceptions of aggression from patients with dementia.	<i>Qualitative</i> Grounded theory.	8 special dementia care units and 3 nursing homes. Canada.	137 NAs.	Focal Group Interviews.	<ul style="list-style-type: none">NAs felt that the dementia disease contributed to causing aggression.Environmental factors were perceived to increase the risk of assault from patients.NA's felt blamed for the incidents, causing them to feel frustrated.Those viewing aggression as part of the dementia disease were less willing to report incidents.	91.7%
Graneheim, Hornsten & Isaksson, 2012.	To explore female professional caregiver's (PC's) perceptions of the reasons for aggression from residents in nursing homes.	<i>Qualitative</i> Content Analysis.	3 nursing homes. Sweden.	41 female PCs: 8 nursing aides, 23 enrolled nurses; 10 registered nurses. Age range: 20-59.	Vignette, followed by open ended questions related to the vignette.	<ul style="list-style-type: none">PC's perceived there to be three main causes for violence amongst residents: 1. the disease process 2. The care approach taken 3. Environmental constraints.	97.2%
Isaksson, Graneheim & Astrom, 2009.	To explore female professional caregivers' (PCs) experiences of violence in nursing homes.	<i>Qualitative</i> Content analysis.	3 nursing homes. Sweden.	20 female professional caregivers. 5 nursing aides, 10 enrolled nurses; 5 registered nurses.	Vignette, followed by open ended questions related to the vignette.	<ul style="list-style-type: none">PCs had varied views regarding the cause of violent behaviour: some attributed it to the dementia disease,	97.2%

Age range: 21-59.		in which case they believed that the violence was not intentional. Others thought that if the patient was lucid in their illness, the violence was intended as the patient was aware of what they were doing.	
		<ul style="list-style-type: none"> • Environmental factors were thought to contribute towards aggression. • Interpersonal factors, such as interactions during personal care were felt to contribute. • Some PCs felt disgusted by the patient and as a result they treated these patients differently to those who had not been aggressive. 	
Isaksson, Astrom & Graneheim, 2008	To explore female caregivers' perceptions of violence in nursing homes.	<p><i>Qualitative</i> Content analysis.</p> <p>Nursing homes. Sweden.</p>	<p>All female professional caregivers: 8 nursing aides, 23 enrolled nurses; 10 registered nurses. Age range: 20-59.</p> <p>Vignette, followed by open ended questions related to the vignette.</p> <ul style="list-style-type: none"> • Violence was often perceived as being a result of the dementia disease, however those lucid in their illness were thought to have intentionally
		97.2%	

Kristiansen, Hellzen & Asplund, 2006	To explore assistant nurses' experiences of job satisfaction when working with behavioural disturbance.	<i>Qualitative</i> Content analysis.	2 supported living dwellings. Sweden.	20 professional workers; 2 registered nurses and 18 support workers. 19 were female, 1 male. Age range: 27-57. years.	Narrative Interviews.	<ul style="list-style-type: none"> • tried to harm them. • Limited resources and inadequate staffing levels were thought to contribute to increased risks of aggression. • Patient humiliation during personal care was thought to influence the likelihood of aggression. • Care staff were often left with marks and scars on their body as a result of aggression. • Aggression caused injury to care staff. • Some nurses felt exposed, vulnerable, insufficient and undervalued when working with behavioural disturbances. These nurses tended to withdraw from the patient. • Some nurses felt empathy for the patient and tried to pacify the patient when the patient was 	97.2%
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Duxbury, Pulsford, Hadi & Sykes, 2013	To explore how staff and relatives perceive and respond to aggressive behaviour from residents with dementia.	<i>Qualitative</i> Content analysis.	6 dementia care units, within 4 nursing homes. United Kingdom.	8 staff members, including 4 care unit managers, 2 registered nurses and 2 care assistants. 6 female and 2 male. Age range: 20-55 years. 8 relatives, including spouses, partners, daughter, niece, son in law and mother.	Semi-structured focal group interviews: staff and relatives were in separate focus groups.	<ul style="list-style-type: none"> Both staff and relatives felt that there were internal (i.e. frustration), external (i.e. environmental constraints) and interpersonal (communication between resident and staff/ client) causes for aggression from residents. Staff and relatives tended to use interpersonal methods as opposed to coercive methods to manage aggression. 	94.4%
Zeller, Dassen, Kok, Needham & Halfens, 2011	To explore how staff perceive and cope with aggression from residents with dementia.	<i>Qualitative</i> Content Analysis.	4 nursing homes. Switzerland.	18 registered nurses, 5 nursing assistants, 7 student nurses. Age: 19-64 years.	Semi-structured focal group interviews.	<ul style="list-style-type: none"> Participants' perceived aggression to be a result of resident factors, such as their dementia, and staff factors, such as feeling under pressure which affected their interactions with residents. Participants tried to pacify the resident, tried to identify the 	97.2%

					<p>residents' needs and tried to provide support in order to manage violence.</p> <ul style="list-style-type: none"> Participants also used humour to cope with experiencing violence.
Macdonald, 2007	To explore care assistants' views and experiences of aggression from dementia patients.	<i>Qualitative</i> No Design reported.	2 care homes. Scotland.	10 care assistants.	<p>Individual semi-structured interviews.</p> <ul style="list-style-type: none"> Participants' attributed aggression to the patients' dementia, however they demonstrated little understanding of how this may impact them. Participants' felt confused as to what care approaches to use and subsequently felt a sense of guilt and despondency.
					75%

3.0 Results

The findings from the 18 studies in this review were organised around the three review aims (see introduction rationale section).

3.1 What are care staffs' perceptions of aggression from dementia patients?

The findings addressing this question were organised into two key aspects of care staff perceptions: the nature of the aggression experienced by care staff and their views about its causes.

3.1.1 The Nature of Aggression Experienced by Care Staff

This theme refers to the most typical forms of aggressive conduct experienced, frequency of incidents and which care staff were most likely to be the victims of aggression from patients with dementia.

Six studies reported the type of aggression experienced by care staff and it was apparent across studies that aggression was a subjective concept. Some care staff viewed aggression as a purely physical act, including; hitting, pinching, grabbing, scratching, sexual advances and having objects thrown at them (Ko Et al., 2012; Kristiansen, Hellzén & Asplund, 2006; Pulsford et al., 2011; Scott et al., 2011), whereas others viewed verbal and emotional abuse as aggressive, alongside physical acts (Bostrom, Squires, Mitchell & Estabrooks, 2011; Hirata & Harvath, 2015).

Four studies reported the frequency of aggression. There were differing levels of aggression reported across these studies, ranging from: 50% physical aggression and 48% emotional abuse (Bostrom et al., 2011); 44% direct physical aggression

(Josefsson, Sonde & Robins-Wahlin., 2007); 78.6% direct and witnessed aggression (Scott et al., 2011). This may be reflective of the differing definitions which care staff had of aggressive conduct and whether they subsequently reported all aggressive acts. The differing definitions of aggression and ways of measuring it across studies and settings is problematic as the extent and nature of aggression may not be accurately reflected in the literature; for example, some studies included only direct aggression, whereas others also included witnessed aggression.

Studies revealed that specialized dementia settings, such as secured units, had a higher frequency of aggression than residential or general aging settings (Josefsson et al., 2007; Ko et al., 2012). This may be reflective of the fact that dementia patients with more complex behavioural symptoms reside at specialized units (Josefsson et al., 2007). This highlighted the need to collate the prevalence of aggression from dementia patients per care facility rather than across all settings and would ensure an accurate estimate of the problem per setting.

Care staff were reported as the most likely victim in all studies. Frontline care staff, such as care assistants, were found to experience more aggression than senior care staff, such as charge nurses and unit managers. This was due to frontline care staff being more exposed to the risk of aggressive behaviour during the course of their daily interactions with patients (Ko et al., 2012). An interesting finding was that frontline care staff who were perceived to have stronger and trusting relationships with patients experienced less aggression. This was because these care staff had been able to learn and understand more about the patients' needs (Ko et al., 2012). Care staff who worked nightshifts and who had a higher case load of patients were more

likely to experience aggression (Ko et al., 2012). This was due to lower staffing levels on nightshifts and lower resources in managing a higher case load, meaning that patient needs were not being met (Ko et al., 2012). The aggression was most likely from patients, with males being perceived as more aggressive (Scott et al., 2011). Although, Josefsson et al. (2007) found that some relatives could also display aggressive behaviours due to their own frustrations about the patients' illness and care.

3.1.2 Perceived Causes of Aggression

Care staff perceived that there were three main causes for the aggression perpetrated by patients with dementia: internal, environmental and interpersonal.

3.1.2.1 Internal Causes

Care staff in 13 studies attributed the causes for aggression to internal factors. In nine studies, care staff perceived aggression as a direct result of the dementia disease. They felt that dementia had caused changes to patients' personality, which increased their level of unpredictability and the risk of aggression (Bostrom et al., 2011; Ko et al., 2012., Morgan et al., 2008, 2012; Scott et al., 2011). Furthermore, the view that patients were no longer capable of understanding their actions due to their cognitive decline was widely adopted (Bostrom et al., 2011; Isaksson et al., 2009; Ko et al., 2012; Morgan et al., 2008, 2012; Scott et al, 2011; Zeller, Dassen, Kok, Needham, & Halfens, 2011). As such, aggression was viewed as an accepted part of the disease and part of their job (Bostrom et al., 2011; Ko et al., 2012; Morgan et al., 2008, 2012; Scott et al., 2011). On the other hand, some care staff felt that those patients who were lucid in their illness did have the capacity to understand

their actions and therefore had intentionally tried to harm them (Isaksson, Astrom, & Graneheim, 2008, 2009). One study found that care staff attributed aggression to the dementia disease, however care staff were unable to elaborate on this, highlighting limited knowledge of the disease and consequences of it (Macdonald, 2007).

Additional to this, five studies revealed that care staff viewed dementia as a mediating factor causing aggression. Their perspective was that dementia had caused patients to experience communication difficulties and as such, they became angry when struggling to express their needs and emotions (Duxbury et al., 2013; Graneheim, Hornsten & Isaksson, 2012; Morgan et al., 2012; Pulsford et al., 2011; Zeller et al., 2011). Similarly, the loss of independence and the awareness of the fading self was thought to contribute to the patient feeling anxious and angry, which could manifest as aggression (Graneheim et al., 2012; Zeller et al., 2011).

In contrast, some care staff attributed the causes of aggression to pre-existing factors prior to the development of dementia. Gender was felt to contribute to aggression, with care staff perceiving that males were more aggressive; this was considered to reflect a higher rate of aggression by men in society as a whole rather than it being linked to dementia (Ko et al., 2012). Additionally, aggression was attributed at times to patients having a pre-existing anti-social personality. These patients were found to have had a forensic history prior to developing dementia (Graneheim et al., 2012). Others considered aggression as a form of attention seeking behaviour in order for patients to establish interactions with care staff (Hirata & Harvath, 2015).

3.1.2.2 Environmental Causes

Environmental factors were perceived to contribute to aggression in eight studies. Managers' lack of awareness as to how to manage aggression meant that inappropriate care approaches were reinforced, which acted to increase aggression (Bostrom et al., 2011). Another cause of aggression was attributed to inappropriate placing of patients in care settings, meaning that patient needs could not be met due to the resources and expertise of care staff not being suitable (Bostrom et al., 2011). Restricted space, high noise levels and cold housing were also thought to increase levels of agitation (Bostrom et al., 2011; Graneheim et al., 2012; Morgan et al., 2008, 2012); one study by Duxbury et al. (2013) found that quieter environments reduced aggression. Care staff perceived that organisational pressures often meant that they had limited time to support patients' needs, which increased levels of aggression from patients (Zeller et al., 2011). Organisational pressure often included high workloads (Zeller et al., 2011) and inadequate staffing levels (Isaksson et al., 2008, 2009). Limited resources, such as a lack of individualised care plans or behavioural plans, often meant that patients' needs remained unmet, increasing aggression (Isaksson, 2008, 2009).

3.1.2.3 Interpersonal Causes

In nine studies, care staff reasoned that interpersonal factors could contribute towards aggression, such as care staff showing a lack of empathy (Zeller et al., 2011), having poor interpersonal skills (Isaksson et al., 2008) and adopting authoritarian styles (Graneheim et al, 2012; Pulsford et al., 2011). Similarly, a lack of understanding of the dementia disease from the family often caused difficult interactions between family and patient, which could result in aggression as an

expression of agitation (Cubit, Farrell, Robinson & Myhill, 2007). Additionally, personal care was identified as causing tension between care staff and patients. The patient often felt violated and humiliated during personal care routines and aggression was perceived as a way of preventing these routines from occurring in order to avoid this (Duxbury et al., 2013; Graneheim et al., 2012; Isaksson et al., 2008; Ko et al., 2012; Morgan et al., 2012; Pulsford et al., 2011). Personal care supported by more than one care staff at a time was considered to be particularly embarrassing for the patient (Isaksson et al., 2009).

3.2 What is the Impact of Aggression on Care Staff from Dementia Patients?

Aggression from patients with dementia had both a physical and psychological impact on care staff.

3.2.1 Physical Impact

Four studies exploring the impact of aggression reported that care staff had sustained physical injuries. Some studies found that 18% of care staff were physically injured (Josefsson et al., 2007), others highlighted that care staff were left with scars and marks on their bodies (Isaksson et al., 2008; Kristiansen et al., 2006) and one study identified that a quarter of care staff sustained minor injuries and half no injury (Pulsford et al., 2011). Care staff working on dementia specific units were more likely to sustain injuries (18%) than care staff working on general aging units (9%; Josefsson et al., 2007); this is in keeping with figures suggesting that specialized units have a higher prevalence of aggressive behaviours from patients.

3.2.2 Psychological Impact

Thirteen studies revealed that aggression had a psychological impact on staff. Research examining the impact of behavioural disturbance on care staff, such as wandering, repetitive behaviours and aggression, found that aggression caused care staff the most personal distress out of any behavioural disturbance (Cubit et al., 2007; Yuki et al., 2010). Those papers focusing on aggression specifically reported that aggression caused care staff to feel upset (Ko et al., 2012), to feel emotionally exhausted (Bostrom et al., 2011) and burnout, with 31% of care staff reporting an intention to resign due to frequent experiences of aggression (Hirata & Harvath, 2015). The way care staff perceived aggression was thought to influence how they felt about it, with those viewing it negatively experiencing more distress (Hirata & Harvath, 2015). In addition to this, other studies revealed that care staff felt fearful of aggression occurring again (Josefsson et al., 2007; Scott et al., 2011), with some care staff experiencing post traumatic stress symptoms and one care staff member meeting the criteria for post traumatic stress disorder (Scott et al., 2011).

Aggression affected care staffs' confidence in their ability to manage aggression; they felt undermined and inadequate due to not being able to control the aggression (Isaksson et al., 2008; Kristiansen et al., 2006). Macdonald (2007) found that care staff felt guilty for not knowing how to manage aggression. For others, they reported a strong dislike of patients who had been aggressive towards them (Isaksson et al., 2009). Care staff who were blamed for the incident subsequently felt angry (Morgan et al., 2008). Conversely, some care staff felt empathy for the patient, believing that they were not who they once were (Cubit et al., 2007; Kristiansen et al., 2006). Furthermore, despite some care staff reporting that aggression had led them to

consider resigning, these same care staff were found to have a high level of job satisfaction (Hirata & Harvath, 2015; Morgan et al., 2012). This was due to feeling supported within their team, highlighting the necessity for team support and cohesion when experiencing such incidents (Hirata & Harvath, 2015; Morgan et al., 2012).

3.3 How do Care Staff Perceptions of Aggression from Dementia Patients and its Impact Affect Practice?

The findings suggest that care staff perceptions of aggression and its impact affect patient care and completion of other occupational tasks.

3.3.1 Patient Care

Five studies indicated that care staff perceptions influenced patient care and aggression management. Studies found that negative attitudes often led to care staff adopting punitive ways of managing aggression, such as restraint or seclusion (Nakahira et al., 2008) and those with positive attitudes tried to understand aggression within the context of dementia and tried to listen to, pacify and support the patient (Kristiansen et al., 2006; Nakahira et al., 2008; Zeller et al., 2011). However, despite some care staff attempting to utilise person centred approaches, at times they felt that these techniques did not work and they had no alternative but to use punitive measures (Zeller et al., 2011). Those care staff who identified interpersonal causes for aggression were more likely to try to adapt their own style to help the patient and to reduce aggression (Duxbury et al., 2013). Macdonald (2007) found that care staff who had a limited knowledge of dementia found it difficult to

know how to manage patient aggression. These care staff often focused on physical needs, such as personal care and feeding routines, rather than exploring the patients' feelings and experiences.

Five studies found that the impact that aggression had on care staff influenced the care of those patients. For example, when care staff felt burnout due to aggression, they often avoided the patient or withdrew from their care completely (Ko et al., 2012; Kristiansen et al., 2006; Scott et al., 2011). Other responses included dissociating or detaching from the patient (Ko et al., 2012), or making sarcastic remarks to patients who had been aggressive (Isaksson et al., 2009). One study found that care staff tried to use humour and laughter in order to diffuse the emotional intensity which occurred with patients who had been aggressive towards them (Zeller et al., 2011).

3.3.2 Occupational Tasks

Five studies described the influence which care staff perceptions and impact of aggression had on occupational tasks in a broader sense. In particular, the ways in which care staff perceived aggression influenced whether they reported the incident. For example, those who had negative attitudes were more likely to report incidents (Nakahira et al., 2008), whereas those who accepted aggression as part of their job due to perceiving it as part of the dementia were less likely to report it (Josefsson et al., 2007; Ko et al., 2012; Morgan et al., 2008). The latter was reinforced by senior care staff (Josefsson et al., 2007). Whilst positive attitudes lead to better patient care, the dilemma is that these care staff seem to report aggression less.

One study found that those who were negatively affected by aggression were more likely to reflect on the incident afterwards and to make suggestions to improve practice (Scott et al., 2011). Whilst reflection is positive, the issue here is that care staff seem to have to be affected in a negative way by patient aggression before improvements to practice are suggested.

4.0 Discussion

The findings from the current systematic literature review highlighted the following:

1) care staff had different definitions of what constituted as aggression from the patient; 2) care staff tried to ascertain the causes of aggression in an attempt to explain why it occurred; 3) aggression had a physical and psychological impact on care staff 4) perceptions and impact had an influence on practice.

4.1 Measuring Hidden Levels of Patient Aggression

The present review highlighted that incident rates of aggression may not be accurate due to the under-reporting of incidents and differing ways of measuring aggression within each facility. This is an issue across healthcare settings; Bowers et al. (2011) found in their systematic review across different psychiatric units that the type and frequency of aggressive conduct varied across units and across countries for a multitude of reasons, such as under reporting, differential definitions of aggression and different reporting systems across facilities. The studies in the current review used different methods of ascertaining aggression levels, such as nurse diaries and in-house reporting scales, all of which were fundamentally unreliable means of gaining an accurate and objective picture of aggression rates and types. These findings have indicated the need for a formal definition of aggression within

dementia care, alongside formal and standardised measurements of aggression both within clinical settings and across the research base in order for all aggression to be recorded accurately (Bowers et al., 2011).

A barrier which has prevented reporting aggression is the view that aggression is a taboo topic in dementia care settings and should be accepted as part of the job (Gates, Fitzwater & Meyer, 1999). Educating care staff on the importance of reporting aggression is essential to overcome this barrier and ensuring that the issue is recognised.

4.2 Perceptions, Attribution Theory and Care Staff Responses

The findings from the current review supported the theory of attribution, which suggests that individuals try to ascertain the root cause underlying why a particular behaviour occurs (Weiner, 1988). Kitwood (1997) explained that care staff either view aggression through a standard paradigm, whereby aggression is caused solely by the dementia disease, or through a person centred paradigm, whereby care staff view aggression as a result of a multitude of factors as well as the dementia disease, such as expressing needs and emotions. The present study indicated that care staff adopted a person centred paradigm of viewing the causes of aggressive behaviours, such as considering the dementia disease, interpersonal and environmental factors (Duxbury et al., 2013). A person centred paradigm is considered best practice when working with patients who have dementia, as the patients' wider needs are more likely to be considered (Stokes & Goudie, 2002). Care staff have historically tended to adopt a standard paradigm of aggression (Astrom et al., 2004), therefore the

present review revealed that in recent years care staff seem to have shifted away from the standard paradigm of aggression (Duxbury et al., 2013).

Viewing aggression from this paradigm had a positive influence on the care approach taken, with care staff adopting person centred approaches to care, such as listening to the patient (Duxbury et al., 2013). This highlighted that the ways in which care staff perceived aggression, affected how they responded to the patient and the care approach they used (Nakahira et al., 2008). This can be explained by the theory of planned behaviour (Ajzen, 1988), which reports that an individual's attitudes and perceptions can influence their behaviour. The present review findings have highlighted that person centred education and training can act to change negative attitudes and promote further use of a person centred paradigm.

4.3 Reflecting on the Impact of Patient Aggression

Only one study in the present review reported that care staff reflected on aggressive incidents afterwards and this was only the case in those who had experienced high levels of disturbance post incident (Scott et al., 2011). It is concerning that reflection was only the case in those most affected as this suggested that aggression had to have extreme impact in order for improvements to practice to be considered (Scott et al., 2011).

Studies found that care staff had a mixture of responses to patients who had been aggressive and that those who held negative attitudes tended to avoid the patient afterwards (Nakahira et al., 2008). This finding highlighted a lack of reflection on how care staffs own responses may have contributed towards a poorer therapeutic

relationship, which could have led to patient aggression (Bonner, 2012). The absence of care staff reflection may highlight a wider issue, such as a lack of formal structures in place in order to provide space for individual and team reflection post incident (Cuttcliffe, 1999). Post incident reflection would help to increase awareness of the impact of aggression on oneself and of how this may influence responses to the patient (Cuttcliffe, 1999).

The studies which focused on the impact of aggression on care staff were predominantly quantitative, utilising cross-section designs. Whilst these studies have made important contributions to this aspect of the literature in terms of revealing the extent of trauma responses, further qualitative exploration of this area may elicit more in-depth insights into the subjective and idiosyncratic impact on each care staffs' lives.

4.4 Implications for Practice and Policy

Based on the current review findings, good clinical governance is essential to ensure that policy and procedures are revised to include the following: it is essential through education and training to raise awareness of the extent of the understandable trauma that aggression from patients can cause care staff. This training should include the message that aggression is no longer a taboo subject in dementia care and that transparency around patient aggression can increase the well being of both care staff and patients (Gates et al., 1999). Formal support structures, such as regular debriefing sessions after incidents, encouragement of reflective practice, ensuring that organisation counselling services are accessible and regular supervision is paramount in order for care staff to feel adequately supported (Nishimoto et al.,

2007). Furthermore, it is crucial to ensure that all care staff receive regular education and training in the area of aggression from dementia patients in order to further promote a person centred paradigm and approach to managing it (Duxbury et al., 2013; Prince et al., 2015).

The above support structures, training and education could be facilitated by Clinical Psychologists within these setting, who due to their own training have an in-depth understanding of the causes of aggressive behaviour, its potential impact, and have knowledge of different ways that could be used to respond and/or address it. There was a mixture of cross sectional survey designs and qualitative methodology employed by studies within the current review to explore impact and perceptions of aggressive behaviour. Papers utilising cross sectional designs tended to provide less in-depth information. Those employing qualitative methodology predominantly utilised content and thematic analyses and whilst these tended to provide more information than quantitative papers, these methods did not provide an extensive in-depth analysis. As such, there was a lack of in-depth information regarding impact and perceptions of aggressive behaviour perpetrated by dementia patients and Clinical Psychologists should be mindful of this whilst facilitating such support structures, training and education. In addition, more exploration in these areas during such sessions may be needed in order to ensure that care staff needs are fully responded to during these sessions.

Part of the role of a Clinical Psychologist involves formulating the best ways of managing behaviours. Clinical Psychologists working in dementia care facilities, such as residential and inpatient units, could provide input into ensuring that clear

expectations and guidelines for the management of aggression from dementia patients are developed. This could help care staff to feel more confident in managing aggression and would ensure that patient needs are addressed during this process (Macdonald, 2007).

One of the limitations of the current literature base is the lack of any formal and standardised definition of and reporting system for measuring aggression across dementia care facilities. Whilst we must be aware of the fact that care staff have varying definitions of what violence is, it is essential for dementia services to try to formally define aggression in order to reduce difficulties in measuring this phenomenon. Formal standardised measurements of aggression need to be established and implemented, with care staff being trained in their use, in order to ensure that aggression is reported consistently and accurately (*Bowers et al., 2011*). Without consideration of more reliable means of defining and measuring aggression, it may also be difficult for Clinical Psychologists to make accurate formulations of the extent of aggression and its types and causes, which could make accurate recommendations as to how to manage this aggression difficult to make.

4.5 Limitations

The present systematic literature review has three main limitations. Firstly, the review was limited to direct care staff and excluded other professional groups such as psychologists, psychiatry and occupational therapy. As such, these findings may not represent a wider range of professional groups. Despite this, it can be noted that the researcher did conduct a broad search initially and noted that papers on other

professional groups were almost non-existent. Secondly, it may have been beneficial to include studies based on care staff attitudes to management approaches of aggression in order to gain a broader understanding of their views in relation to specific management strategies. Thirdly, trying to integrate the results from both quantitative and qualitative papers in order to gain a coherent picture proved difficult at times. This may be due to the differing aims and depth of results reported within quantitative and qualitative papers. As such, it was a challenge to build a narrative which was not fragmented.

4.6 Future Research Directions

The current review has highlighted six areas for future research development. Firstly, the literature base may benefit from employing more in-depth qualitative methodology to further explore impact and perceptions of aggressive behaviour perpetrated by dementia patients. Secondly, future research may benefit from exploring the perceptions of a wider range of professional groups in order that their views are heard. Thirdly, the present review highlighted that aggression was rated the most distressing behavioural symptom (Cubit et al., 2007; Yuki et al., 2010). Despite this, other behavioural and psychological symptoms of dementia, such as repetitive behaviours and apathy, do have a negative effect on care staff (Cubit et al., 2007; Yuki et al., 2010). It is important to explore how other behavioural and psychological symptoms of dementia may impact on care staff in more detail.

Fourthly, one study in the present review, by Hirata and Harvath (2015), highlighted that appraisal of aggression increased burnout in care staff. Research investigating the relationship between perceptions of aggression and care staff stress is limited;

this area is important to explore further in order to fully understand the contributions to staff burnout.

Fifthly, whilst the present study adopted a care staff perspective, Duxbury et al. (2013) found that relatives had similar perceptions of aggression to care staff; therefore, it is essential to ensure that research on relative perspectives continues to expand and is not neglected. In the same way, perspectives of aggression more generally in an aging population, with or without physical ailments or mental illness, is important to consider as research suggests that aggression is a wider issue in healthcare (Isaksson et al., 2009). In-depth, qualitative methodology, should be utilised where possible for all of the above, as this would ensure that a rich understanding is gained.

Finally, despite sexual acts being included in most definitions of aggression across the literature in more recent years, some studies within the context of dementia have considered sexual behaviours as a separate ‘challenging behaviour’ to aggression or within the context of patient sexual expression or sexual identity (Stubbs, 2011). As such, these papers would not have been recognised as part of the current broad search conducted on aggression. This has highlighted the need for sexual behaviours from dementia patients to be researched more closely within the literature.

Having been trained in both research and clinical skills, Clinical Psychologists should take an active role in moving this literature base forward to enable further insights into these areas in order to inform clinical practice.

5.0 Conclusions

The present study aimed to update and expand on a previous review by Scott et al. (2010) by reviewing the most recent literature and addressing some of the previous reviews limitations. This was achieved by addressing the following questions: 1. What are care staff perceptions of aggression from dementia patients? 2. What is the impact of this aggression from dementia patients on care staff? 3. How do care staff perceptions of aggression and the impact of it affect practice?

Recent research has highlighted that care staff have begun to consider a wider range of factors which may contribute to causing aggression; this highlighted the importance of continued education and training in this area in order to promote a person centred paradigm of aggression. Recent studies have highlighted the extent of psychological trauma which care staff experience as a result of aggression, with some care staff experiencing post-traumatic stress disorder. Care staff perceptions of aggression and its impact has a direct influence on care approaches used and whether aggression is reported. The literature suggests that reflection on these incidents is limited.

These findings have implications for practice and further research. Formal support structures, reporting procedures and education and training are essential in ensuring that aggression is understood, reported and managed appropriately. Future research should focus on exploring the views of other professional groups and adopting qualitative methodologies in order to gain rich insights. Finally, the views of relatives, explorations of other behavioural and psychological symptoms and further

research into sexual behaviours from patients with dementia is essential to develop the research base.

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Chapter 2: Empirical Paper

**Title: Nurses' Experiences of Violence whilst Working
on Adult Acute Psychiatric Facilities in the
United Kingdom**

*Written in preparation for submission to the Journal Issues in
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*The abstract will be shortened to the required length before
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7,991 words.

Abstract

Aims: Nurses working in adult acute psychiatric facilities are at times subjected to violence from patients, which has been shown to have a significant impact on their physical and psychological wellbeing. The current study aimed to address a gap in existing research by conducting an in-depth exploration of how nurses experience violence from patients.

Method: Eight nurses who worked on adult acute psychiatric facilities in the United Kingdom, UK, were interviewed. The content was analysed using Interpretative Phenomenological Analysis (IPA).

Results: The findings were organised into three superordinate themes: 1) Personal Perceptions of Violence, 2) Impact of Violence and 3) Survival Strategies. Nurses made sense of what violence meant to them and the possible reasons for violence. Violence had a physical, psychological, occupational and relational impact on nurses and they tried to manage this by adopting individual and group level survival strategies.

Conclusions: Nurses' experiences are discussed in terms of their implications for clinical practice and policy and directions for future research were detailed.

Keywords: psychiatric, nurses, violence, interpretative phenomenological analysis.

1.0 Introduction

1.1 Defining Violence and Adult Acute Psychiatric Facilities

The International Labour Office, International Council of Nurses, World Health Organisation and Public Services International (ILO, ICN, WHO & PSI, 2002) have described violence towards nurses as any verbally aggressive conduct, threat or physical or sexual assault from the patient against the nurse, which can cause the nurse physical, sexual, emotional or psychological harm. Farrell (1997) suggests that the most meaningful way to understand violence is in terms of a persons own subjective experiences. It is this experiential-based definition that will be employed throughout this study.

In the current study, Adult Acute Psychiatric Facilities refers to any inpatient ward in the United Kingdom, UK, that provides treatment to those who are sixteen and above and are suffering from acute mental health difficulties, such as schizophrenia, personality disorder(s), depression and anxiety, but who do not require treatment from psychiatric intensive care units, PICU (National Mental Health Development Unit, NMH DU, 2012; The National Health Service, NHS, Confederation, 2012). In recent years, these facilities have transformed to single gender wards (Hawley, Paler, Jefferies, Gale & Vincent., 2013) and are often located in psychiatric hospitals separate to general hospitals (The NHS Confederation, 2012). The ratio of women to men working as nurses in psychiatric hospitals tends to be approximately 65:35 (Bowers, Jones & Simpson, 2009).

1.2 Background

Over recent years, there has been a move towards treating people with mental health difficulties largely in the community as opposed to acute psychiatric facilities. This was due to National Health Service, NHS, re-structuring, which aimed to improve greater social inclusion of individuals with mental health problems within communities and to increase their human rights (Gilburt, Peck, Ashton, Edwards & Naylor, 2014). As a result, patients are currently admitted to acute psychiatric wards when they are severely unwell and/or when they present a significant risk to themselves or others and as such, approximately one in five patients have committed a physically violent act on these wards in recent years (Lozzino, Ferrari, Large, Nielssen & Girolamo, 2015; Ward, 2013).

Recent international research indicates that the UK has one of the highest levels of violence from patients within in-patient settings, along with the Netherlands and the United States of America, USA (Bowers et al., 2011). Despite conflict and containment strategies being implemented within the UK to reduce violence, it remains an issue within acute psychiatric facilities (Bowers et al., 2011; Chambers, Kantaris, Guise, Valimaki, 2015; Lozzino et al., 2015; Rose, Evans, Laker & Wykes, 2013). Bowers et al. (2011) reported that in the UK, nurses are subjected to violence more than any other mental health professional, with 72% of nurses experiencing violence from patients on inpatient wards. Violence can cause staff injury, post-traumatic stress, anxiety, sickness and low staff retention rates, all of which result in a lower quality of care for patients and financial strain on the NHS (Bowers et al., 2011; Wykes & Whittington, 1998). Qualitative studies have aimed to explore the

experiences of violence from patients from the nurses who are subjected to it in order to gain a better understanding (Cuttcliffe, 1999).

1.3 Nurses' Experiences of Violence

Research by Cuttcliffe (1999) suggested that nurses had their own personal construct of what violence was depending on their own beliefs and experiences. Furthermore, Benson et al. (2003) found that nurses tried to make sense of why the patient had been violent; nurses believed that patients could be violent due to their mental illness. They reasoned that these patients had a lack of capacity to understand their behaviours whilst unwell and as such, they were not viewed as responsible for their actions (Benson et al., 2003).

Studies have also highlighted a variety of emotions experienced in response to violence from patients. Research by Bimenyimana, Poggenpoel, Myburgh and Van Niekerk (2009), Camuccio, Chamber, Valimaki, Farro and Zanotti (2012) and Zuzelo, Curran and Zeserman (2012) has highlighted that nurses often felt helpless in the face of violence and resentful towards the patient for causing harm to them. Camuccio et al. (2012) and Chambers et al. (2015) found that nurses felt fearful and anxious in relation to not knowing whether the patient would attack them again. In contrast, some nurses have felt empathy for the patient (Zuzelo et al., 2012).

Research suggests that nurses employ various coping strategies in order to manage their experiences of violence and associated emotions. Ward (2013) and Zuzelo et al. (2012) found that some nurses kept their emotions related to these experiences

private so that this did not effect the rest of the team, whereas others found comfort in discussing their experiences and emotions with their colleagues.

1.4 Rationale and Aims for the Current Study

The majority of studies over the past 15 years have used descriptive, thematic and content analyses, which has not enabled an in-depth exploration of the individual's experiences. A critique of the current research suggests that the literature would benefit from a more in-depth understanding of nurses' experiences of violence from patients, including how nurses feel in response to violence and how they deal with these experiences and their feelings (Camuccio et al., 2012; Chambers et al., 2015; Rose et al., 2013; Ward, 2013).

There have only been two studies in this area that employed in-depth analyses, however they were conducted over 10 years ago and may not reflect nurses' experiences within the current UK NHS context. Research has largely been conducted in other non-UK countries. Therefore, these findings may not be cross-culturally relevant to the current UK context. Likewise, some studies do not use a homogenous sample and are based on a mixture of inpatient settings, for example forensic and acute psychiatric wards. Consequently, the results may not be transferable to nurses working in a purely acute facility, which the current study was focused on.

Based on the highlighted gaps in the literature and that violence remains an issue in current UK NHS adult acute psychiatric facilities, the current study aimed to explore nurses' lived experiences of violence from patients within these facilities. It was

intended that this study would further the understanding of these experiences within the current UK NHS context.

2.0 Methodology

2.1 Research Design

Due to the exploratory nature of this study, Interpretative Phenomenological Analysis (IPA), a qualitative methodology, was thought to be most suitable. IPA is an idiographic, phenomenological approach, which allowed the researcher to explore each nurses' experience of violence and the meaning of these experiences (Smith, Flowers & Larkin, 2009). IPA is also interpretative, which enabled the researcher to explore how each nurse made sense of and understood their experiences of violence (Smith et al., 2009). Additionally, IPA acknowledges that the researcher played an active role whilst trying to interpret and make sense of the nurses' experiences (Smith et al., 2009).

2.2 Participants

The researcher completed eight interviews with nurses. These included two men and six women. At this point sufficient breadth and depth of interview data was judged to be reached (Pietkiewicz & Smith, 2012; Smith et al., 2009). Table 1 below details the inclusion and exclusion criteria for this study.

Table 1: Participant Inclusion and Exclusion Criteria

Participant Inclusion Criteria	Participant Exclusion Criteria
Registered nurses.	Not a registered nurse.
Have worked on an adult acute psychiatric facility in the UK.	Has not worked on an adult acute psychiatric ward in the UK. Works on the PICU and not the acute wards; PICU wards are structured differently, have more security and containment measures and higher staffing levels, therefore nurses from these wards were not included as there were too many differences between PICU and acute wards (Bjorkdahl, Palmstierna & Hansebo, 2010). Works on acute wards for physical complexity and organic disorders; these wards are not mental health specific and therefore did not meet the criteria for this study.
Have experienced violence from patients whilst working on these wards within the UK.	Has not experienced violence from patients whilst working on these wards within the UK.
Currently working for a selected NHS Trust on one of the adult acute psychiatric wards in the UK.	Does not work for the selected NHS Trust.

Table 2 below details the characteristics of the nurses who took part in this study.

Each of the nurses were given a pseudonym in order to protect their identity.

Table 2: Characteristics of Participants

Nurse	Age Range	Gender	Ethnicity	Nursing Grade	Length of time as a registered nurse	Length of time working on the adult mental health acute wards	Working hours	Gender of Ward	Type of training in relation to violence on the wards
John	31-40	Male	White British	Band 5 nurse	2 years	2 years	Full time (37.5 hours).	Women	Management of actual and potential aggression (MAPA).
Simon	21-30	Male	White-British	Band 5 nurse	3 years	2 years	Full time (37.5 hours).	Women	MAPA
Mary	51-60	Woman	White-British	Band 5 nurse	8 years	2 years	Full time (37.5 hours).	Men	MAPA
Sarah	41-50	Woman	White-British	Nurse and deputy ward manager	13 years	11 years	Full time (37.5 hours).	Men	MAPA
Amy	21-30	Woman	White-British	Band 5 nurse	3 years	3 years	Full time (37.5 hours).	Women	MAPA
Samantha	31-40	Woman	White-British	Nurse and ward manager	14 years	14 years	Full time (37.5 hours).	Men	MAPA
Amara	31-40	Woman	Black-African	Nurse and deputy ward manager	11 years	11 years	Full time (37.5 hours).	Women	MAPA
Hilary	51-60	Woman	White-British	Band 5 nurse	5.5 years	5.5 years	Full time (37.5 hours).	Women	MAPA

2.2.1 Recruitment

Nurses were selected across five adult acute psychiatric wards. These wards were situated within two psychiatric hospitals, both of which were part of one NHS Trust. A poster advertising the study was placed in each nursing office in order to raise awareness of the project (see Appendix D). A participant information sheet and consent form was placed in each nurse's individual drawer in the nursing office in order to invite them to take part in the study (see Appendices E and F). The ward managers and the researcher also discussed the study with nurses. Nurses then expressed an interest in the study by emailing or speaking to the researcher directly. All eight nurses who expressed an interest in the study were interviewed.

2.3 Procedure

2.3.1 Ethical Procedures

This study complied with research and ethical standards set by the British Psychological Society (BPS, 2011). It was approved by Coventry University Ethics Committee and gained NHS Trust Research and Development approval (see Appendices G and H).

2.3.2 Materials

A semi-structured interview schedule was developed based on the identified gaps in the literature (see Appendix I). This was reviewed by the researcher's supervisors and the researcher also gained feedback from the nurses regarding the interview questions and slight amendments were made.

The interview questions were open-ended and non-leading. This ensured that nurses were able to explore their own personal experiences without being led by the researcher (Smith et al., 2009).

2.3.3 Interview Procedure

Nurses read the participant information sheet and were given time to ask any questions before the interview started (see Appendix E). The nurses then gave informed consent (see Appendix F) and completed a demographic questionnaire (see Appendix J). The interviews took place in private rooms on the NHS Trust site. The interviews ranged from 21 to 58 minutes, with a mean of 48 minutes. Each nurse was then debriefed and given a written copy of the debriefing sheet, which included information on the trust support service, which they could contact if required (see Appendix K).

2.4 Analysis

Each interview was transcribed verbatim and identifiable information was removed. Nurses were given a pseudonym to protect their identity. The data was then analysed according to Smith et al.'s (2009) IPA data analysis procedure (see Appendix L). Two excerpts from the transcripts are provided in order to demonstrate theme development during the analysis process (see Appendix M). Similar themes from each transcript were grouped together and written on separate pieces of paper, with related themes written in the same colour (see Appendix N). These were then checked for patterns across transcripts and organised into superordinate themes (see Appendix O).

2.4.1 Credibility of Analysis

In order to ensure that the process was valid and credible, the following audit was carried out during the analysis process (Smith et al., 2009). Firstly, the nurses were informed that they could request a copy of their transcripts to make any amendments. One nurse did request their transcript, however following a discussion they did not request any changes to be made. Secondly, the researcher discussed the initial note taking and theme development with the supervision team, after which any necessary changes were made. Thirdly, a trainee peer who was familiar with IPA coded a section from two transcripts (see Appendix P) This was then checked against the original coding and no new codes or themes were noted. The final themes were discussed with the researcher's supervision team.

2.4.2 Researcher's Position

The researcher had worked in several inpatient settings and experienced the effects of violence. A bracketing interview technique was carried out with a member of the supervision team before the research interviews took place and the researcher kept a reflective journal throughout the process. This ensured that the researcher was aware of her own thoughts and feelings prior to and throughout the research process in order that this would not effect making sense of the data (Finlay & Gough, 2003). The researcher also had supervision during the research and analysis process in order to manage her own subjectivity during the process.

3.0 Results

As a result of data analysis, three superordinate themes were identified. These were: personal perceptions of violence, impact of violence and survival strategies. The superordinate themes were made up of ten subordinate themes. Table 3 below details these themes and the prevalence of nurses who endorsed them. These themes were discussed and represented using verbatim quotes from the nurses and convergence and divergence between nurses' experiences were highlighted.

Table 3: Superordinate and Subordinate Themes

Superordinate Theme	Subordinate Theme	Prevalence of Subordinate Theme
Theme 1: Personal Perceptions of Violence	1a. "To me, that's Violence" 1b. "Making Sense of Violence".	1a. All nurses. 1b. All nurses.
Theme 2: Impact of Violence	2a. "Physical Effects" 2b. "Psychological Aspects" 2c. "Therapeutic Relationship"	2a. 6 nurses: John, Simon, Mary, Amy, Sarah and Samantha. 2b. All nurses. 2c. All nurses.
Theme 3: Survival Strategies	3a. "Soldiering on" 3b. "We've got each other" 3c. "Personal Healing" 3d. "Needing Consequences"	3a. All nurses. 3b. All nurses. 3c. All nurses. 3d. All nurses.

3.1 Theme 1: Personal Perceptions of Violence

This superordinate theme encapsulated the personal meanings that nurses attached to the violence they experienced, their understanding of the causes of violence and the lack of understanding of others who do not work on the wards, including directors, senior management and police officers. This contained the subordinate themes "to me, that's violence" and making sense of violence.

3.1.1 Theme 1a. “To me, that’s violence”

All of the nurses tried to make sense of what violence meant to them and it was apparent during each interview that the definition of violence was personally constructed. For instance, Mary told me that:

Violence to me, would result in somebody ending up in hospital with injuries. That to me is violence but like you say, you could talk to someone else and they might class somebody as somebody...pushing someone, or grabbing them as a violent action, I wouldn't but I think that is because of my personal background I think that is why I have a higher tolerance of what I would class as violence.

(Mary, lines 133-138).

For Mary, physical violence generally caused a serious impact on the individual. Mary felt that the language surrounding the topic of violence was important and reflected that the wording used to describe patient incidents by staff members affected the way that patient was viewed. For example, Mary also stated that:

Sometimes people use quite emotive language and write things down in notes and say so and so assaulted me and I've said to people, you need to be really careful about what you you know write because that affects whether people like the patient...for me, violence is extremely is a strong word.

(Mary, lines 120-123).

Sarah, Simon and Amara all described experiencing emotional abuse as violence. The three nurses conveyed their belief that violence was not only physical but could also affect the recipient emotionally, as Sarah expressed:

I suppose, it's anything where people feel threatened, so verbal hostility...But I think it is anything where there is any intent of something else where you might get hurt or feel you know you may get hurt.

(Sarah, lines 236-244).

Simon and Amara voiced that racial abuse was also a form of violence. Simon described witnessing racial abuse towards other black members of staff, perpetrated by patients. He highlighted the personal offence that racial abuse caused him, despite not being personally targeted, as he conveyed:

There's still a lot of racial abuse from patients. So like, if that's happening, even though it's the other person [black staff member] who is being abused, they might not be offended whereas with me like I will step in and say no that's not right.

(Simon, lines 198-201).

Similar to Simon, Amara felt personally offended and hurt by racial abuse. Amara experienced direct racial abuse from other members of staff; she felt excluded from them due to her African ethnic group. Amara dealt with the abuse she experienced

by accepting it as something which she expected to experience in life, contrasting to Simon's choice to retaliate against it in order to put a stop to it:

In terms of racial abuse, you experience it with staff too and I think to me, it's one of those things that you experience in life...it's just the little things like walking to meetings with your colleagues and they choose to talk amongst each other, to me it is discrimination...I think it is because of my race.

(Amara, lines 211-215).

In contrast to all other nurses, Sarah narrated that she had experienced a patient suicide as a violent act, by expressing:

I suppose it is a violent act, it is violence towards themselves, but I wouldn't deem it in the same way as violence towards others, I suppose it is different. That was really stressful, really it is...I think because there's no resolve from it, there's nothing you can do.

(Sarah, lines 558-577).

During the interview Sarah conveyed the extremely stressful impact of experiencing this patient's suicide and the difficulty she had in finding a resolution.

3.1.2 Theme 1b. "Making Sense of Violence"

All the nurses tried to make sense of why patients had been violent and expressed that there were a variety of reasons. Six of the nurses interviewed felt that gender

was an important factor in relation to acts of violence, especially since wards had changed to single sex. Some trends emerged, including the tendency for more male patients to use drugs with an associated increase in the risk of violence, with women patients being viewed as more emotionally challenging and women staff being viewed as more 'helpless' when caring for male patients who were violent. Sarah explained:

Yeah, I mean I'm trying to think, there's no, obviously now we're segregated so it's male and females, so that makes a difference. I think that impacts on the ward massively. I think with the males, you get a particular, I mean particularly with the drugs, you tend to get a culture of them sort of, and drugs increase violence...whereas females there is more the manipulation which plays with your emotions, the psychology, the self-harming.

(Sarah, lines 95-101).

During the interview with Mary, it became apparent that her views were different to other nurses and she attributed this to her own background (see Mary, lines 133-138 in theme 1a). She reported that "for most men there is an ingrained thing in them that you do not hit women" (lines 73-74). Unlike the women staff above, Mary stated that she did not feel at risk from male patients.

All of the nurses, except for Mary, expressed the view that mental illness contributed to the causes of patient violence. Violence was more understandable when the

patient was considered unwell due to the view that those unwell did not have capacity to understand what they were doing. For instance, Samantha told me:

I suppose you...with the patient that is unwell you would accept their behaviour more than somebody who wasn't as unwell, because you can see a reasoning behind it then, you can see that it's not an...it's...I suppose it's about intent really. They're not intentionally out to harm you, they don't understand what they're doing, it's just the way they're thinking at the time.

(Samantha, lines 107-111).

The majority of the nurses felt that senior managers and police officers did not understand violence in the way that nurses did. They felt that this lack of understanding led to a stigma that all mental health patients were at risk of being violent, therefore violence should be tolerated by nurses. For instance, Amy felt that:

The polices' attitude was vile, they kind of said, well what do you expect from mental health patients, it's part and parcel of your job.

(Amy, lines 423-425).

3.2 Theme 2: Impact of Violence

This superordinate theme represented the impact that nurses felt that violence had on them. This included physical, psychological, occupational and relational impact. These have been encapsulated in the subordinate themes “physical effects”, “psychological aspects” and “therapeutic relationship”.

3.2.1 Theme 2a. “Physical Effects”

Several of the nurses described the physical impact that violence had on them. There were differing types of physical impact and differing perceptions of these. Increased adrenaline in response to violence was viewed as functional. For instance, John said, ‘Your adrenaline carries you on’ (line 436) and Sarah suggested that adrenaline prepared her to take action by suggesting that:

The adrenaline kicks in and you get that, you know your heart beat and you know and you think, let’s get some help, let’s see how we can try and nip this in the bud before it gets worse.

(Sarah, lines 302-304).

In contrast to John and Sarah, Amy communicated the negative physical effects of violence when she said:

I never had a back issue before. So I've actually not been taking part in MAPA [Management of Potential and Actual Aggression] for the best part of two years, which is part, a massive part of my role here. So it's quite debilitating. The GP has said that it's never going to get any better.

(Amy, lines 146-149).

The impact of Amy’s injury prevented her from being able to fully carry out her job as a nurse.

On the other hand, Mary described a process of making sense of the psychological origins of physical symptoms, by saying:

I would get up but I felt sick in my stomach. I thought oh my God if I have to deal with someone being aggressive, my nose used to hurt [nose was broken during a previous violent incident from a patient]. I know it's probably quite a psychological thing but I used to rub my nose [rubs nose]...I was scared.

(Mary, lines 232-238).

It appeared that when Mary was in similar situations to the violence she had experienced previously, she recalled this through responses in her body.

3.2.2 Theme 2b. "Psychological aspects"

All of the nurses experienced numerous psychological responses to violence, including feeling a lack of control during and immediately after the incident. This lack of control, leading to a sense of helplessness, powerlessness and fear, is illustrated by Amy's narrative, as she described:

Um...that kind of...lack of um...control of the shift and you can't...the sense of not being able to keep yourself or your colleagues safe; so how are you meant to keep your patients safe? It's terrifying to me, that thought you know.

(Amy, lines 224-226).

All of the nurses' accounts suggested they had experienced understandable trauma responses in relation to the violence they had been subjected to. These psychological effects arose some time after the incident, as John related:

When I went home that night it sort of hit me in the night, I woke up with a nightmare, she was stabbing me with some scissors [laughs] and I woke up and I sat with my Mrs and I sort of burst into tears.

(John, lines 158-160).

John's description of the incident during the interview was detailed and vivid and his speech quick in pace. This suggested that he could still be processing the psychological effects this incident had left him with. Similarly, Simon experienced understandable hyper-vigilance after being bitten by a patient. He described continually checking himself for symptoms of Human Immunodeficiency Virus (HIV) and hepatitis whilst he waited for his blood tests to return to confirm whether he had contracted a blood borne virus from the patient. He reported: "you kind of almost become like a hypochondriac...if I got a temperature, I would automatically pin it down to that" (lines 97-99).

Both Amara and Hilary spoke of the experience of violence affecting their confidence. Hilary stated "it takes your confidence" (lines 123-124). The word "takes" suggested that this felt out of Hilary's control and that she had been robbed of her confidence. Both Amara and Hilary described a process of self-doubt and evaluating their performance after experiencing violence, as Amara expressed: "you ask yourself what am I doing wrong?" (line 225). Hilary seemed aware that her loss

of confidence after the violence she experienced caused her to fear negative evaluation from others and at this time it was harder to challenge these beliefs. For example, Hilary felt that:

When your confidence has been knocked you do wonder if people are saying things or whatever. You can usually rationalize it totally. But when your confidence isn't good you can always think the world's against you.

(Hilary, lines 556-559).

3.2.3 Theme 2c. “Therapeutic Relationship”

All of the nurses spoke of their responses to patients who had been violent towards them or others, which they perceived had either strengthened their “therapeutic relationship” with the patient, or “damaged” it. Several nurses appeared to undergo a process of trying to empathise with and understand the patient. Mary discussed her experience as follows:

After that [coming back to work after being injured by the patient and reassuring him that she was okay and there was no animosity from her] we actually did develop quite a really good [laughs] rapport and I found out things about him that I didn't know about, different musical tastes, we were chatting about things. I think because I was determined to because I didn't want him to feel bad.

(Mary, lines 610-613).

Mary related that showing compassion towards the patient strengthened their therapeutic relationship and her knowledge of him as a person. In contrast, Hilary conveyed being more conflicted between needing to have a relationship with the perpetrator as she felt this was her duty and having a genuine wish to use her own difficult experiences to help the patient, as she stated:

But you're there as a professional; you're there to nurse them, not judge them, and that's how you do it, isn't it? And I think because you go through life and you've had experiences, and you can help people because you've been there and done that.

(Hilary, lines 508-511).

In contrast to Mary and Hilary, for Amy and Amara the violence had affected the therapeutic relationship negatively. Amara described the following:

Like I don't really want to be sitting there with you having any meaningful conversation because of how I'm feeling...but I think, definitely if they've apologised I would be more relaxed around them, it almost makes you feel like you back to doing your work...

(Amara, lines 370-384).

Amara felt that there was no choice but to detach herself from the patient and have a more superficial relationship, unless the patient showed remorse, in which case she was more able to do her work effectively. Unlike Amara, during the interview with

Amy she was much more absolute by saying that “that therapeutic relationship that we’d had had gone” (lines 246-247).

3.3 Theme 3: Survival Strategies

This superordinate theme encapsulated the strategies nurses employed in order to survive facing violence. It contained four subordinate themes: “Soldiering on”, “We’ve got each other”, “Personal healing” and Needing Consequences.

3.3.1 Theme 3a. “Soldiering on”

All nurses described a process of adapting to their circumstances following a violent incident in order to survive, demonstrating a level of resilience. They often did this by “soldiering on” (John, line 234) and, as Samantha explained, accepting that “ward life carries on” (line 235). During the interview, John narrated that subsequent to a violent incident his priority was to survive the day, as he expressed:

You haven’t got time really to process it, you know, you’ve literally got to put all of your thought processes and things into the day to get through the day you know.

(John, lines 256-258).

John voiced that “I’ve been able to get it out of me pretty quick so I can carry on” (lines 284-285). Through his narrative, he described a process whereby he may have cut off or dissociated from the impact of violence and this helped him to carry on with his job. However, Hilary indicated, by using the metaphor of a swan, that carrying on was difficult and that she may have seemed okay on the surface, but

underneath she was struggling: “like a swan where you’re looking all okay and then you’re paddling underneath” (lines 579-580).

All nurses described the need to reflect as a way of enhancing resilience and coping. For example, Samantha voiced that it was important to take “that time out to reflect and make sure you’re okay” (lines, 148-149). Samantha explained that some time after the incident, when there was more space, a process of reflection and learning was more possible:

After everything has settled down there is more space to, I suppose to just look back to see if there was anything that we could have done to prevent the incident happening in the first place.

(Samantha, lines 161-163).

3.3.2 Theme 3.b. “We’ve got each other”

All of the nurses spoke of supporting each other as a way of surviving violence. There was a sense of camaraderie between fellow nurses, which acted to unite them through mutual support of each other. Simon explained that during a restraint “we were just making fun of each other” (lines 281-282). Simon’s expression of them “making fun of each other” highlighted the use of humour to survive adversity and to bond with one another.

Both Simon and Samantha felt responsible for looking out for their team. Simon narrated that:

Even though I wasn't supposed to get involved with other staff members, I still felt that I shouldn't just stand there and watch, I wanted to help, I'm more likely to put myself at risk to help someone else.

(Simon, lines 186-188).

For Simon, there appeared to be an instinctual drive to protect his team, despite being told not to get involved in restraints due to being injured in a previous incident. Simon described a self-sacrificial act, with the purpose of promoting the survival of his fellow colleagues. Likewise, Samantha expressed that "they're part of my team and just...you don't want your staff to get hurt" (lines 270-271). She used the phrase "my team", which suggested that she felt accountable for the safety of her team as part of her managerial role.

In contrast to this, all except Mary and Samantha felt that those in senior positions and outside of their nursing group were not supportive enough. For example, Amy expressed that she had felt pressured to come back to work without support or having the time away from work that was necessary for her to recover.

Amy reported:

I was heavily encouraged...much like if you fall off a horse, get back on it. That was the way that it was put to me, that I shouldn't be staying off for any length of time. And I don't think I was physically or mentally ready to come back, but that's the way it was put to me by management so...

(Amy, lines 154-158).

Several of the nurses gave suggestions as to how they could feel more supported in their roles, including attending assertiveness training to improve communication and confidence and having debriefing after incidents with psychology professionals, such as assistant and qualified Psychologists. Amara explained that “we need someone to always like, have sessions, we don’t have that luxury” (lines 325-326). She believed that debriefing sessions were important, yet felt this was not considered an essential part of their job by management.

Amara indicated that women patients could be more challenging to work with, particularly if you were a woman staff member. She explained that “they [women patients] can be very sensitive you know, like saying “you didn’t say good morning to me!” Males wouldn’t behave that way!” (lines 462-463) and expressing “women [patients and staff] we clash” (line 346). As such, she suggested that nurses rotate wards on a regular basis in order to prevent burn out, especially on women only wards, and for there to be a balance of women and male staff working on wards for women.

Many of the nurses felt that the police could help more, perceiving that they were better equipped to deal with violent incidents. For example, Amara said, “I think the police could help more because they have tasers and things” (lines 339-340).

3.3.3 Theme 3c. “Personal Healing”

All nurses spoke of “personal” ways of surviving violence and its impact and this assisted them to heal. Some nurses described an avoidant style of coping with the impact of violence, which they found helpful, as Mary expressed:

Just like an ostrich in the sand, I would come back to work and forget about it, that’s just me.

(Mary, lines 300-301).

Mary further narrated that this was “partly down to my personality” (line 296), therefore she seemed to attribute this style of coping to her identity.

Several nurses expressed the need to implement clear boundaries in order to separate their work and home lives. This allowed them to distance themselves from work and heal after the impact of violence. Similar to Mary, Simon attributed this to him being “a very laid back person” (line 128), therefore this pragmatic way of coping was part of his identity.

Hilary, on the other hand, was less concerned about removing herself from the impact of violence. Instead, she sought help from the trust counselling service and

she also focused on restoring her sense of self by immersing herself in the things that she enjoyed. Hilary related that:

I said I wasn't going to stew at home. I made sure...I like walking.

Then there's my animals and that. So I did a lot of doing that, reminding myself of the things that I enjoy. And I also did that deliberately because I also knew that I was...brewing on things a lot.

(Hilary, lines 294-297).

This also acted to distract her and prevent rumination about the incident. In contrast to Hilary, whilst interviewing Amara she voiced that she preferred to heal privately and she explained that this was partly due to her African background:

It's a cultural thing, I think crying or if someone hold me hand or comfort me [laughs]. I wouldn't feel comfortable...I probably talk to myself first before I talk to somebody else.

(Amara, lines 283-286).

3.3.4 Theme 3d. "Needing Consequences"

All of the nurses felt that violence should not be part of their job and that there needed to be consequences for the patient, both to set an example of what would not be tolerated and for them to survive working in that environment. Several nurses felt inner urges to retaliate and protest against violence, however this conflicted with their ethical duties as a nurse, which prevented them.

Amara told me:

Angry, you want to lash out and any those f... words back at them, you want to tell them what hurts you, but you don't want them to see you as vulnerable, you want them to see you as authoritative. And that is the difficulty, because you don't get that [to stick up for yourself], because they are louder than you. You can't shout at them in that same tone of voice.

(Amara, lines 240-244).

Amara revealed a need to appear in control in order to protect herself from patients, yet she perceived patients to have more power than nurses causing her to feel as though she could not effectively do this. Prosecuting the patient was seen as one way of standing up for oneself and protecting the team in order to promote survival. For John, this was also his indirect way of re-gaining the control lost when experiencing violence. John narrated:

Well obviously at the time I was trying to get the prosecution so I was doing my best to try to pursue that for myself and for my colleagues and to you know certainly send a sign that you know, this is not tolerated you know, she could do that to someone else, like if I didn't do anything.

(John, lines 224-228).

Unlike other nurses, Samantha viewed prosecution as a pragmatic solution to inform other staff of the patient's risks rather than as a way to regain power and to right the wrongs that were done to her, as she voiced:

It's not that we want to prosecute them but it is just that people have built up a risk history about people, to make people more aware. So it's about consequences really.

(Samantha, lines 121-123).

4.0 Discussion

The aim of the current study was to explore nurses' experiences of violence from patients during their employment on adult acute psychiatric facilities in the UK. The study resulted in three superordinate themes, including personal perceptions of violence, impact of violence and survival strategies, which are discussed below. Clinical implications, study limitations and recommendations are also detailed.

4.1 Discussion of Findings

The nurses in the current study tried to understand what violence meant to them and why patients could be violent. Supporting Cutcliffe (1999) and Farrell's (1997) studies, the nurses interviewed had different views of what constituted violence. This finding was consistent with Kelly's (1963) Personal Construct Theory, which suggests that individuals attribute meaning to events based on their personal constructs and experiences. A new finding of the current study was that suicide was considered one of the most stressful violent acts for nurses to deal with. Racial abuse against staff, perpetrated by patients and staff members, was also a key issue drawn

from the findings and revealed the need to address this more broadly (Becares, 2009).

Consistent with Benson et al. (2003), nurses felt that violence could be attributed to the patient's mental illness. Benson et al. (2003) found that nurses did not tend to perceive personality disorder as a 'mental illness', therefore having a personality disorder was not viewed as sufficient grounds for influencing the patients' behaviour. The nurses I spoke to in the present study did not seem to have such misconceptions, perhaps demonstrating a better understanding of personality disorders. However, the nurses I interviewed did not consider other broader factors or psychological difficulties, such as conflict being a result of the service approach being used (Duxbury, Pulsford, Hadi & Sykes, 2013), behaviours being an expression of need (Kitwood, 1997), or behaviour as a result of attachment difficulties or trauma (Hunter & Maunder, 2016). This indicated the need for further education about these issues, as this could positively influence both the views of and treatment of patients (Scott, Ryan, James & Mitchell, 2010).

The present study supported existing literature that indicates that nurses view the segregation of gender on wards as contributing to violence and that women staff felt more vulnerable on male only wards (Hawley et al., 2013). Women patients were viewed as too sensitive and emotionally challenging by some nurses in this study and this was consistent with existing findings arguing that women are often misinterpreted and given 'pathological labels' for their needs, highlighting issues with a lack of gender sensitivity on these wards (Wirth, Galen & Bodenhausen, 2009). Misconceptions of mental illness, led to denial of support for nurses, from

senior management and police officers and remains an issue that needs to be addressed (Hansson & Markstrom, 2014).

Supporting existing qualitative studies, the current findings conveyed that violence had an emotional impact on nurses, as nurses experienced a lack of control, anxiety, helplessness and empathy (Camuccio et al., 2012; Chambers et al., 2015; Ward, 2013; Zuzelo et al., 2012) and violence lowered their confidence and led to self-doubt (Ward, 2013). In addition to this, the current findings indicated that the impact of violence was broader and revealed further psychological, physical, occupational and relational responses to violence. These are discussed further below.

Analysis of the current findings highlighted a need to consider support for those who suffer traumatic responses to violent experiences (Bowers et al., 2011; Scott, Ryan, James & Mitchell, 2011; Wykes & Whittington, 1998). The nurses I spoke to described experiencing physical embodiment of their distress. Several authors, including Rothchild (2000), argue that the body and mind are not separate and trauma can be stored in the body's nervous system. Therefore, when the individual is reminded of the traumatic incident, they recall this through bodily responses, for example physiological sensations or pain (Rothschild, 2000). This emphasises the importance of ensuring that nurses and managers are aware that psychological trauma can manifest itself in many ways in order that physical embodiment of distress is appropriately recognised and responded to.

The nurses I interviewed felt that the physiological sensations of adrenaline helped to prepare them to manage violence and seek help. Research supports the finding

that nurses need to feel prepared to be able to deal with violence (Cuttcliffe, 1999). Some nurses reported the debilitating effects of physical injury subsequent to violence, which is well supported by high rates of NHS staff sickness due to physical injury from patients (Bowers et al., 2011).

In line with previous research by Bonner (2012), nurses interviewed responded to the patient in numerous ways after experiencing violence. Of particular interest was that violence had strengthened some nurse-patient relationships. Yalom & Leszcz (2008) explain that when nurses demonstrate altruism, nurturance, modelling interpersonal skills and normalising human suffering, change within the patient is more likely to occur. It could be that some of the nurses in the present study utilised these skills, including showing altruism, trying to repair the therapeutic relationship and using one's own difficult experiences to help the patient, which in turn helped to strengthen their rapport with them.

The nurses in this sample employed strategies to try to survive violence, including 'soldiering on', despite the impact that violence had on them. This reflected a wider systemic issue, whereby systems tend to encourage a 'tough skin' and carrying on despite adversity (Zuzelo et al., 2012). In addition to this, some nurses may have dissociated from distress in order to help them to continue to function at work and preserve themselves (Michelson & Ray, 1996). These findings identified a continuing issue, which was that nurses did not have the necessary time to reflect on and process the incidents (Cuttcliffe, 1999), which could be a result of the pressures of operating within the current resource stricken NHS (Gilburt, 2015). Analysis of the interviews also suggested that as a possible result of a lack of space to reflect on

violence and its impact, nurses tried to survive by attempting to re-gain power and control through opting to prosecute patients for their violent actions. This highlighted the need for assertiveness training, which could help nurses to feel more confident in directly managing conflict with patients.

The nurses in this study tried to find their own individual ways of coping, indicative of post-traumatic growth and self development after a traumatic incident (Joseph, Murphy & Regel, 2012). Furthermore, the influence of culture was relevant to how nurses managed the impact of violence. This supports the wider literature base that recognises that emotions are expressed and managed differently across cultures (Murphy-Berman & Berman, 2003).

Alongside individual development, and supporting research by Ward (2013), nurses tried to survive by supporting each other. The use of humour amongst fellow nurses within the present study highlighted efforts to increase confidence in the face of violence (McCreaddie & Wiggins, 2008), to manage feeling threatened (Geisler, 2010) and to create a cohesiveness between fellow nurses in order to feel secure and protected within the group (Beck, 1997). This cohesion is a particularly useful survival strategy in a currently resource limited and pressurised NHS.

4.2 Clinical Implications

The present study highlighted the need to understand the extreme and varied impact that violence has on nurses' lives. It is essential that NHS governance consider implementing formal support structures for nurses, such as: regular debriefing sessions after violent incidents, including patient suicide, regular scheduled

supervision and higher staffing levels in order that these structures can take place (Chambers et al., 2015). These structures would promote reflection, learning and healing. Clinical Psychologists working within the adult acute psychiatric services may be best placed to facilitate support structures, such as debriefing sessions. One reason for this is that Clinical Psychologists are often separate from nursing teams and nursing supervision and/ or management, enabling a safe and confidential space for this reflection and healing to occur without the fear of competency being evaluated or the fear of being blamed for the incident itself.

Additionally, raising awareness of the Schwartz-rounds project, which is a monthly confidential meeting for all professionals to share their experiences at work in order to support one another, is essential to promote further support structures for staff (Goodrich & Cornwell, 2012). Considering ways to make the trust counselling service more accessible to staff would also be helpful.

The nurses in the current study had only received training in how to manage violence through the use of de-escalation and restraint techniques. It would be helpful to deliver workshops to nurses and senior management to raise awareness of the varying ways that trauma and distress can manifest itself after violent incidents, including the physical embodiment of distress, in order that this is recognised and responded to appropriately.

Education and training on the underlying reasons for violence from patients is essential for nurses, senior management and police officers in order to expand their understanding and approach to this subject (Chambers, Gillard, Turner &

Borschman, 2012). Gender sensitivity training could be helpfully included in this training to ensure that relevant and gendered issues in particular are addressed (Wirth et al., 2009). This training and education could be facilitated by Clinical Psychologists, as their training and job role requires an understanding of why such behaviours occur, how the impact of it could manifest itself and the best ways to respond to this. The reflective nature of the Clinical Psychology role would enable a reflective learning environment in order for staff to explore their own positions in relation to the violence they have experienced and the subsequent impact on them.

The option of attending assertiveness training, through the trust counselling service, to increase confidence in managing conflict would be beneficial. Furthermore, liaison between mental health and justice systems needs to be improved to increase more helpful responses to crises (Hansson & Markstrom, 2014).

It is essential for policies to include a formal definition of violence, which includes emotional and racial abuse and patient suicide, and to ensure that there is an effective procedure for reporting these incidents. Including nurses in relevant policy and procedural decisions is also essential in order to ensure that nurses voices and experiences are responded to and that they feel more empowered within the service. Despite nurses voicing that violence was not acceptable, they have limited resources and security measures on acute psychiatric wards to be able to effectively enforce a zero tolerance of violence. Consideration of changes in policy to how these incidents are prevented and managed and considering additional security measures is essential to protect staff and patients on the acute psychiatric wards.

4.3 Methodological Issues

The current study should be considered in light of two main limitations. The first limitation concerns the sample, which was limited to nursing staff and therefore, the results are not transferable to other staff disciplines who experience violence. Additionally, the sample consisted of six women and two men; whilst this approximately reflects the ratios of women: men working as nurses on the acute psychiatric wards, it may have been beneficial for higher numbers of men to be included in the study. Secondly, triangulating the method of data collection to include other methods, such as focus group interviews, alongside individual interviews, may have contributed towards a deeper understanding of experiences both on an individual and group level and may have also provided helpful support structures for the nurses involved in the research.

4.4 Recommendations for Future Research

Future research could benefit from focusing on the following areas. Firstly, similar research could be carried out with a wider range of staff disciplines and acute facilities, such as PICU and organic acute wards, in order to consider their experiences in light of the findings of the current study.

Secondly, further exploration of humour within the context of coping with violence may be beneficial, alongside further in-depth research focusing on the physical embodiment of distress in nurses following trauma and how this can be recognised and responded to. Thirdly, further exploration of staff responses to the nurse-patient relationship subsequent to violence is required, alongside detailed exploration of staff experiences of violence perpetrated by other staff on these wards.

Finally, it may be of benefit for future studies to explore police officers' understanding of violence perpetrated by patients in psychiatric facilities and to conduct joint research to determine how mental health and justice services can become better integrated in order to work more effectively together.

5.0 Conclusions

The current study explored nurses' experiences of violence whilst working in adult acute psychiatric facilities in the UK. Nurses experienced psychological, physical, occupational and relational effects as a result of violence. Whilst they demonstrated resilience in managing the impact of this, more attention needs to be paid to creating space for nurses to reflect on their experiences and the impact of violent incidents. Educational and formal support structures need to be put in place to provide more effective support for managing the impact of violence on staff. The meaning of violence was personally constructed by each nurse, demonstrating a need to reconsider how violence is defined within policies and procedures that exist for reporting and managing violence.

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Chapter 3: Reflective Paper

Title: My Research Journey

Overall chapter word count (excluding references): 3,662 words.

1.0 Introduction

Reflective practice has been described by Rogers (1967) as a process of learning through experiences. During clinical and research practice it is critical to consider how our values, beliefs and experiences may influence our work (Hughes & Youngson, 2009). This enables the clinician-researcher to be mindful of the decisions they make and to ensure their practice and research is ethical (British Psychological Society, BPS, 2009).

Reflection has been an essential feature throughout my training as a Clinical Psychologist. Therefore, this chapter is a reflective account of my experiences of the research process whilst completing my thesis. In line with the qualitative approach undertaken for my empirical chapter, I adopted a reflexive stance and considered the development of self-awareness and the importance of this whilst conducting the research. A pivotal part of the research has been completing my own reflective journal in order to note my experiences and explore my own assumptions, beliefs and sense making. In line with this, many of the reflections included are themes from my journal.

I discuss six main themes that emerged during the research process, the majority of which also paralleled key aspects of nurses' experiences, as illustrated in both the literature review and empirical chapters. Firstly, I discuss the development of my research interest. Secondly, I reflect on my own personal perceptions of violence, which in part informed my interest in this topic. Thirdly, I discuss the impact that violence had on the nurses in my study and on myself. Fourthly, I draw a parallel between the nurses' experiences of survival, highlighted in my empirical study, and

my own as a Trainee Clinical Psychologist. Fifthly, I will discuss how I managed my different roles as a clinician and researcher during the research process, followed by final reflections on how I have developed as a professional throughout this journey.

2.0 Beginning the Research Process

Interpretative Phenomenological Analysis (IPA) acknowledges that the researcher plays an active role in making sense of individuals' experiences (Smith, Flowers and Larkin, 2009). According to Smith et al. (2009), the researcher is both alike and different to the participant. Both are trying to make sense of the participants' experiences, yet the researcher is also separate and doing this through their own lens (Smith et al., 2009). Beger (2015) argues that in order that the researcher remains neutral enough for the meaning of the participants' own accounts to be recognised, reflexivity is crucial. Reflexivity involves a process of self- reflection in order for the researcher to expand their awareness of their own assumptions and beliefs in relation to the topic area and to be mindful of these when making research decisions (Berger, 2015).

In keeping with these principles, I tried to maintain a reflexive stance from the start of the research. To begin this, I considered why I was interested in the subject area and what it meant to me. As chapter two states, under the researcher's position section, I worked in various inpatient settings as a healthcare assistant and also as an assistant psychologist prior to training. Whilst working as a healthcare assistant within a nursing team, I personally experienced violence on many occasions. Violence had detrimental effects on myself and the nursing team. The nursing team appeared to suffer from violence to a greater extent, which the literature suggests is

due to the fact that nurses are on the frontline (Bowers et al., 2011). I witnessed the team feeling “burnt out and helpless” as a response to the violence they endured and many staff voiced that no-one listened to their concerns in relation to their experiences. I began to think that raising an awareness of their voice and their experiences of violence would help others to understand this on a deeper level, would contribute to existing literature in this area and in turn would assist nurses to try to influence more positive practice and policies in this area.

During the research process, it was important to remain aware of my own motivations. I was aware that my position from the beginning of this project was not neutral. Undertaking a bracketing interview with one of my supervisors reinforced the need for me to be mindful of my own beliefs, values and assumptions and to remain open to the reality that each nurse may have experienced violence differently. I felt that IPA would be a suitable methodological approach for my empirical research as this would give nurses an opportunity to voice their in-depth experiences, both as a professional group and as individuals (Smith et al., 2009). Whilst the design of my study was the most suitable to use to address the gaps in the literature, I realised that my interest in IPA also stemmed further back than this thesis. As an undergraduate, I had the opportunity to use IPA in three projects and developed a passion for this qualitative approach, believing that it enabled participants to make sense of their experiences and that the in-depth analysis of their accounts contributed to the literature. To me, the unity of both phenomenology and hermeneutic theories was crucial in order to ascertain both the individuals’ experience and meaning of it (Smith et al., 2009). Whilst I was aware of the importance of positivist paradigms, an interpretivist paradigm was vital to me in order that peoples’ experiences were heard,

understood and hopefully acted upon. I was excited both to further the understanding of nurses' experiences of violence by using IPA and also to get in touch with this approach again as I enjoyed using it.

Reflecting on the choice of this study design led me to wonder whether research could ever be truly neutral, or whether it is always influenced by the researcher's own epistemological position. During the process of designing my research aim I was mindful of my own reflexive stance and beliefs and ensured that the research aim developed and the design chosen were appropriate and essential in order to address the gaps in the literature.

3.0 Personal Perceptions of Violence

I found Personal Construct Theory particularly relevant when trying to expand my self-awareness during the development, recruitment and analysis stages of the research process. Kelly (1963) suggests that we all perceive and give meaning to our experiences based on our personal constructs of the world. In light of this, I reflected again on my experiences as a healthcare assistant and the violence that I had experienced. Similar to the care staff and nurses in the previous two papers, I tried to make sense of what violence meant to me and how my own perceptions of it were also partly constructed based on my experiences and beliefs (Kelly, 1963). When I worked in inpatient services, a hostile look or threatening body language felt like violence to me. This was something that caused me great anxiety as I feared that either my colleagues or I would be hurt. I reflected on my own background; both growing up and in my adult life I had not experienced any violence. This influenced my definition of violence and my sensitivity towards it. I held the belief that violence

included any verbal or emotional abuse and any physical act which caused disrespect or threat to the other individual.

These beliefs influenced the way I perceived behaviours at work; anything that was of threat to myself or my colleagues' safety was 'violence' to me. Being aware of this sense-making process for me was essential throughout the development of my research. In addition to the literature on defining violence (Farrell, 1997), I became personally aware that violence was a subjective and idiosyncratic experience. As such, I made the decision that each nurse in my study could be given the opportunity to define violence by their own experience of it (Farrell, 1997). Furthermore, being aware of my own perceptions of violence was important whilst analysing the findings from both the literature review and empirical study. An awareness of my own definition of violence enabled me to ensure that this did not influence the analytical process.

4.0 Impact of Violence

It is important to consider the impact that qualitative research interviews of a sensitive nature can have on both the participants and the researcher (Dickson-Swift, James, Kippen & Liamputtong, 2007).

When conducting the interviews, I was struck by the level of psychological disturbance that each nurse had experienced as a result of violence. The majority of nurses spoke of reliving the incident some time after it had happened. At points, I felt moved when listening to their accounts and felt a sense that this may have been the first time that they had been able to fully recount their experience with someone

else and that this had been restorative for them. They felt passionate about having their voice heard and trying to raise awareness of their experiences.

Whilst none of the nurses informed me of any negative effects or distress experienced throughout the interview process, I did consider both before and during the interviews how difficult it could be to recount their experiences and that perhaps the interview process itself could stir up emotions for them. These issues were fully considered when applying for ethical approval and each nurse was informed of the support structures in place should they need further support. It reassured me to know that I had fully considered the distress that these interviews could have on the nurses.

Alongside this, it was important to remain aware of my own responses to each nurses' accounts in order to consider my own well-being and to ensure that my responses did not lead the questions I asked, or the analysis process. I had particularly strong feelings during my interview with Simon. Simon expressed being bitten by a patient and having to wait six months to find out whether he had contracted a blood borne virus. He described becoming hyper-vigilant to any physical change in his body and said that he remained preoccupied with fears about his physical health for the duration of this time. It appeared as though he was understandably experiencing some traumatic stress effects (Morris, 2015). I also identified with Simon, as I had experienced being injured during a restraint in one inpatient service I worked in. I too had to wait to see if this had affected my physical health. I recall similar responses to this injury, including becoming hyper-vigilant and checking for symptoms of the Human Immunodeficiency Virus (HIV) and Hepatitis.

I felt a deep sadness for Simon whilst hearing of his distress and that he had suffered in silence. His descriptions were also normalizing for me and for the first time since my own experience, I considered that I had not been alone in my responses to the incident I experienced. I felt an urge to tell him that he was not alone either; however, I refrained from doing so and continued to listen to his accounts. It was important to identify my own responses to Simon's experiences during and following the research interview as this stirred up emotions in myself, which I thought I had dealt with. Through recognising this I was able to take care of myself and seek support through my peers and research team. Equally, whilst researcher disclosure has often been considered beneficial and acceptable during interviews (Reinharz & Davidman, 1992), I was able to take a step back and realize that in this case this interview was about Simon's experience and not mine and that it would not have been appropriate to share my experience.

5.0 Survival Strategies

All of the nurses spoke of having to adapt to the circumstances they were in in order to survive and they all did this by "soldiering on". I could relate to this feeling in two different ways. Firstly, I could relate to "soldiering on" after I had been injured as a healthcare assistant. Secondly, I could relate to this at times during Clinical Psychology Training. I will focus on the latter. On occasions during training, I felt that there was a conflict between wanting to reflect as a developing practitioner, and needing to get through and survive. I could relate to Hilary's metaphor in Chapter Two (Power, Liebling, Colombo & Wilcockson, 2016), whereby she described herself as a swan, "looking all okay" on the outside yet "paddling underneath". At times on placement, I could relate to trying to seem okay, to seem contained and

competent, yet feeling as though it was a struggle at times to juggle all of the competing demands of training and that this was taking its toll on me. This metaphor was also relevant to my personal life, whereby I felt that no-one could truly understand the demands of Clinical Psychology Training unless they were doing it themselves; I had to just get on with it and survive. In the same way as the nurses I spoke to described, I found most of my comfort and grounding from my fellow trainees. They truly understood the experience of being a Trainee Clinical Psychologist and I sought comfort in the fact that “we’ve got each other”.

Alongside this, in some ways, I could relate to the process of post-traumatic growth and personal healing which Hilary spoke of. Joseph, Murphy and Regel (2012) described post-traumatic growth as a process whereby the individual begins to accept that life may not be the same after a traumatic event and they begin to re-build a new life for themselves. Whilst training has been a positive experience for me, I initially found the process of reflecting on my own difficult experiences overwhelming and traumatic; similar to the nurses in this study, it was almost as though I was reliving these experiences again. Like Hilary, after seeking support and processing a lot of this I was able to go through a process of “personal healing” and growth and I have now re-built my life in a way that I am happier with. As with the nurses in this study, this process of breaking down defences and building my own self back up has acted to improve my resilience as a person and a clinician (Lemma, 2003).

6.0 Wearing Multiple Hats

Johnson and Clarke (2003) found in their study that researchers undertaking qualitative interviews can experience a conflict between their different roles. During

the interviews, I could relate to feeling a conflict between my role as a clinician and that as a researcher. There were times where I utilised the skills acquired as a Trainee Clinical Psychologist as these were beneficial during the interviews. This helped me to build the necessary rapport for the nurses to feel comfortable enough to share their experiences with me (Liamputtong & Ezzy, 2005). However, I was also mindful not to facilitate a psychologist-client relationship as I was aware that the nurses may not have wished to share information that could distress them or which they may regret sharing after the interview (Kvale, 1996). I ensured that I informed each nurse that they could stop the interview at any point and informed them of support structures they could utilise after the interview.

Likewise, I was mindful of trying to maintain different boundaries as a researcher to those I was used to in my Trainee Clinical Psychologist role (Dickson-Swift et al., 2007). There was one example in particular where I felt an inclination to adopt a natural Psychologist role, yet I refrained from doing so. An example of this was during my interview with Hilary. Hilary told me that her confidence had been knocked due to the violence she experienced and that she had received counselling in order to help her process this incident. I found that, at times, she looked to me for reassurance and it was difficult for me to avoid shifting into a clinical role in order to reinforce the principles of her counselling. In order to manage this, I used neutral phrases such as “okay” and “can you tell me more about that?” and did not enter into making interpretations or asking therapy type questions. I tried to keep to the objectives of the research and to be as neutral as possible. I felt uncomfortable doing so, as I was aware of a strong pull to take responsibility and try to help people. My discomfort was lowered by the fact that Hilary was aware of further support from the

participant information sheet and our discussion of the debriefing information after the interview.

7.0 Developing as a Clinician and Researcher

Conducting this piece of research has been essential to my development as a clinician. Focusing on a staff population for my empirical study has been particularly interesting and has taught me the importance of facilitating regular education and implementing support structures for staff. I have learnt the importance of the role of a Clinical Psychologist in helping to ensure that these are facilitated and have tried to move these findings forward within my fifth placement. During this placement, which was within a community mental health team, I facilitated multidisciplinary consultation sessions and workshops for staff in order to increase their knowledge of attachment behaviours within psychiatric services and how services could better support patients. This involved guiding discussions about clients and reflecting on patient difficulties and staff practice. This coincided with my research and I enjoyed supporting the team and influencing systems. It was fascinating to experience staff enthusiastically participating in exercises and reflecting on working with complex clients together. I hope to continue to try to influence staff training, consultation and systems in my final placement.

I have also developed as a researcher and it has been inspiring to consider the impact that research can have on practice. For me, clinical practice and research go hand-in-hand and whilst I have learnt the benefit of influencing systems and staff through clinical services, I have also found the value of research for providing a platform for clinical influence to be possible.

Whilst working as a Trainee Clinical Psychologist within the NHS, I have experienced the frustrations of limited resources and changes within these structures that have contributed towards some clinicians feeling more helpless and powerless to make a difference. By identifying recommendations to improve practice and systems through research, funding can be more accessible and thus the opportunity to change can more readily occur. One nurse said to me during her interview that she felt that research was very important to influence practice and policy and that without this, staff on the “frontline” do not have a voice. This statement resonated with me and has inspired me to advocate for staff involvement in system decisions.

Both the literature review and empirical papers highlighted important implications for policy and practice, including the need for staff education, formal support structures and standardised reporting systems for aggression. I therefore intend to disseminate the findings and recommendations from my empirical paper to teams within the adult acute psychiatric facilities that took part in this study. I hope that implementing formal support structures and increasing better responses from senior management and police officers will help nurses to feel better supported at work. Through education and training, nurses and senior management will more easily recognise and respond to the various ways which trauma can manifest after experiencing violence. Disseminating my findings could also encourage system reviews of the definition of violence and how it is reported. Furthermore, my findings highlight that additional security measures and resources need to be put in place to prevent and contain violence. Publishing my literature review will also raise further awareness of the need for support, education and formal reporting procedures for care staff experiencing aggression within dementia care facilities.

During the research process, I learnt the importance of ensuring that I gained permission from the director of acute services and the lead matrons of the service before I began recruitment. Ensuring that respect is given to those who work in and lead these clinical areas by fully informing them of the procedures that the researcher will be implementing is essential. At the same time, I learnt that whilst it is important to consider peoples' opinions and to respect this, it is also crucial to remain within the procedures set out by your approved ethics. At times this felt like a difficult balance to strike. I tried to manage this by ensuring that all of the necessary people were kept informed of my decisions and procedures and that these were supported by the Trust Research and Development Department and the University Ethical Committee. This worked well and the lead matron and director of acute services thanked me for my diligence.

Another area of development as a researcher has been to learn to trust in the research process. At times, I struggled with the uncertainty of not knowing how successful recruitment would be within the time frame given for the thesis and I often worried about the literature review process and whether it would come together. I learnt that barriers, difficulties and uncertainty are natural parts of carrying out research and that solutions can be found within the research team and with peers.

8.0 Conclusion

The process of carrying out research, in part fulfilment of my Doctorate in Clinical Psychology, has influenced my development as a clinician and as a researcher. Whilst it has been a challenge at times, my research developed into a meaningful project for myself and the nurses who participated in this study. I have learnt the

value of self-reflection during this journey and the influence that this can have on research. The findings of both the literature review and empirical paper have important implications for clinical practice as well as clear directions for future research. This journey has highlighted the benefits of exploring how people construct meaning from their experiences, how they make sense of the impact of these and how they survive and grow from them. These phenomena and sense-making processes will be important for me to hold in mind throughout my clinical practice and involvement in future research.

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Appendices

Appendix A

Author Instructions for the Journal *Dementia*

Aims and Scope

The aim of the journal is to publish original research, or original scholarship contributions, to the existing literature on social research and dementia. The journal will consider all relevant designs, methods and methodologies that meet this aim. The journal will also consider narrative-based and/or other forms of literature review that seek to answer social research questions in dementia studies; however, such reviews need to have a systematic approach to literature collation and reporting. All original research published in the journal must comply with ethical approval processes.

Dementia is hosted on SAGE track; a web based online submission and peer review system powered by ScholarOne™ Manuscripts. Please visit <http://mc.manuscriptcentral.com/dementia> to log in and submit your article online.

All original papers must be submitted to the journal via the online system. The online submission process follows a standard format and contributors will be asked to confirm that all authors have agreed to the submission and that the article is not currently being considered for publication by any other paper-based or electronic journal. All submissions should avoid the use of insensitive or demeaning language. In particular, authors should use ‘dementia-friendly’ language in positioning people living with dementia in their article and avoid using pejorative terms such as ‘demented’ or ‘suffering from dementia’. We recommend that authors refer to the Dementia Engagement and Empowerment Project (DEEP) guidance [<http://dementiavoices.org.uk/resources/deep-guides/>], which was developed by

people living with dementia and offers a range of advice and support, including writing dementia-friendly information. Alternatively, Alzheimer's Australia sets out guidelines for dementia-friendly language.

[<https://fightdementia.org.au/sites/default/files/NATIONAL/documents/lang....>]

Please also consider how you are using abbreviations in your submission. Whilst QoL (for quality of life) and MMSE (for Mini-mental State Examination) may have common usage, please try to avoid unnecessary abbreviations in the submission of your manuscript, such as PWD (for people with dementia) and abbreviations that detract from the overall flow of the manuscript.

Reviews: Books and educational resources for review / requests to review should be sent to Dr Caroline Swarbrick, School of Nursing, Midwifery and Social Work, Jean McFarlane Building (6th floor), The University of Manchester, University Place, Oxford Road, Manchester. M13 9PL, UK (email: caroline.swarbrick@manchester.ac.uk)

Innovative Practice: The journal also welcomes short papers on various aspects of innovative practice in dementia care. Jo Moriarty at King's College London, UK (jo.moriarty@kcl.ac.uk) is the Editor for this section of the journal which is published twice a year. Submissions for Innovative Practice are generally between 750 – 1500 words, but longer papers can be received in exceptional circumstances. Please visit <http://mc.manuscriptcentral.com/dementia> to log in and submit your Innovative Practice article online. This section of the journal is not peer reviewed.

For all other original articles, including literature reviews, *Dementia* operates a strictly anonymous peer review process in which the reviewer's name is withheld from the author and the author's name from the reviewer(s). We aim for each manuscript to be reviewed by two reviewers but the Editors reserve the right to return the decision to the author with more, or less, reviews depending upon the context and circumstances of the submitted article. All manuscripts are reviewed as rapidly as possible and correspondence with the main author will be undertaken electronically. All submitting authors should be mindful that their manuscript may be reviewed by a person living with dementia as part of the journal's Editorial Board.

Manuscript Preparation

The text should be double-spaced throughout with generous left and right-hand margins. Brief articles should be up to 3000 words and more substantial articles between 5000 and 6000 words (references are not included in this word limit). At their discretion, the Editors will also consider articles of greater length. Innovative practice papers should be between 750-1500 words.

Keywords and Abstracts: Helping Readers Find Your Article Online

The title, keywords and abstract are key to ensuring readers find your article online through online search engines such as Google. Please refer to the information and guidance on how best to title your article, write your abstract and select your keywords by visiting SAGE's Journal Author Gateway Guidelines on How to Help Readers Find Your Article Online. The abstract should be 100-150 words, and up to five keywords should be supplied in alphabetical order.

Journal Style

Dementia conforms to the SAGE house style. Click [here](#) to review guidelines on SAGE UK House Style.

Lengthy quotations (over 40 words) should be displayed and indented in the text.

Language and terminology. Jargon or unnecessary technical language should be avoided, as should the use of abbreviations (such as coded names for conditions). Please avoid the use of nouns as verbs (e.g. to access), and the use of adjectives as nouns (e.g. demented). Language that might be deemed sexist or racist should not be used.

Abbreviations. As far as possible, please avoid the use of initials, except for terms in common use. Please provide a list, in alphabetical order, of abbreviations used, and spell them out (with the abbreviations in brackets) the first time they are mentioned in the text.

Ethics

When reporting experiments on human subjects, indicate whether the procedures followed were in accordance with the ethical standards of the responsible committee on human experimentation (institutional or regional) or with the Declaration of Helsinki 1975, revised Hong Kong 1989. Do not use patients' names, initials or hospital numbers, especially in illustrative material. When reporting experiments on animals, indicate which guideline/law on the care and use of laboratory animals was followed.

Reference Style

Dementia adheres to the APA reference style. Click [here](#) to review the guidelines on APA to ensure your manuscript conforms to this reference style.

Corresponding Author Contact Details

Provide full contact details for the corresponding author including email, mailing address and telephone numbers. Academic affiliations are required for all co-authors. These details should be presented separately to the main text of the article to facilitate anonymous peer review.

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Appendix B

Quality Assessment Framework (Caldwell, Henshaw & Taylor, 2005)

Scores: 2 = Yes; 1 = Partial; 0 = No.

Assessment of Quantitative Papers

1. Does the title reflect the content?
2. Are the authors credible?
3. Does the abstract summarize the key components?
4. Is the rationale for undertaking the research clearly outlined?
5. Is the literature review comprehensive and up-to-date?
6. Is the aim of the research clearly stated?
7. Are all ethical issues identified and addressed?
8. Is the methodology identified and justified?
9. Is the study design clearly identified, and is the rationale for choice of design evident?
10. Is there an experimental hypothesis clearly stated? Are the key variables clearly defined?
11. Is the population identified?
12. Is the sample adequately described and reflective of the population?
13. Is the method of data collection valid and reliable?
14. Is the method of data analysis valid and reliable?
15. Are the results presented in a way that is appropriate and clear?
16. Are the results generalizable?
17. Is the discussion comprehensive
18. Is the conclusion comprehensive?

Total out of 36.

Assessment of Qualitative Papers

1. Does the title reflect the content?
2. Are the authors credible?
3. Does the abstract summarize the key components?
4. Is the rationale for undertaking the research clearly outlined?
5. Is the literature review comprehensive and up-to-date?
6. Is the aim of the research clearly stated?
7. Are all ethical issues identified and addressed?
8. Is the methodology identified and justified?
9. Are the philosophical background and study design identified and the rationale for choice of design evident?
10. Are the major concepts identified?
11. Is the context of the study outlined?
12. Is the selection of participants described and the sampling method identified?
13. Is the method of data collection auditable?
14. Is the method of data analysis credible and confirmable?
15. Are the results presented in a way that is appropriate and clear?
16. Are the results transferable?
17. Is the discussion comprehensive
18. Is the conclusion comprehensive?

Total out of 36.

Appendix C

Author Instructions for the Journal *Issues in Mental Health Nursing*

Aims and Scope

Issues in Mental Health Nursing is a refereed journal designed to expand psychiatric and mental health nursing knowledge. It deals with new, innovative approaches to client care, in-depth analysis of current issues, and empirical research. Because clinical research is the primary vehicle for the development of nursing science, the journal presents data-based articles on nursing care provision to clients of all ages in a variety of community and institutional settings. Additionally, the journal publishes theoretical papers and manuscripts addressing mental health promotion, public policy concerns, and educational preparation of mental health nurses. International contributions are welcomed.

Publishing Ethics

The Editors and Taylor & Francis Group are committed to the highest academic, professional, legal, and ethical standards in publishing work in this journal. To this end, we have adopted a set of guidelines, to which all submitting authors are expected to adhere, to assure integrity and ethical publishing for authors, reviewers, and editors.

Taylor & Francis is a member of the Committee of Publications Ethics (COPE). COPE aims to provide a forum for publishers and editors of scientific journals to discuss issues relating to the integrity of their work, including conflicts of interest, falsification and fabrication of data, plagiarism, unethical experimentation, inadequate subject consent, and authorship disputes. For more information on COPE

please visit <http://publicationethics.org>.

All papers should be submitted via the journal's online Manuscript Central site <http://mc.manuscriptcentral.com/umhn>. Microsoft Word files are best for the text of the document. Tables and figures should be submitted as separate individual files. Manuscript and other requirements conform to the "Uniform Requirements for Manuscripts Submitted to Biomedical Journals" established by the International Committee of Medical Journal Editors (N Engl J Med 1991; 324:424-8).

Each manuscript must be accompanied by a statement that it has not been published elsewhere and that it has not been submitted simultaneously for publication elsewhere. Authors are responsible for obtaining permission to reproduce copyrighted material from other sources and are required to sign an agreement for the transfer of copyright to the publisher. As an author you are required to secure permission if you want to reproduce any figure, table or extract text from any other source. This applies to direct reproduction as well as "derivative reproduction" (where you have created a new figure or table which derives substantially from a copyrighted source). All accepted manuscripts, artwork, and photographs become the property of the publisher.

All parts of the manuscript should be typewritten, double-spaced, with margins of at least one inch on all sides. Number manuscript pages consecutively throughout the paper. Authors should also supply a shortened version of the title suitable for the running head, not exceeding 50 character spaces. Each article should be summarized in an abstract of no more than 100 words. Avoid abbreviations, diagrams, and

reference to the text. Please also provide 4 relevant keywords with your manuscript.

Declaration of interest. It is the policy of all Taylor and Francis, to adhere in principle to the Conflict of Interest policy recommended by the International Committee of Medical Journal Editors (ICMJE).

(<http://www.icmje.org/index.html#conflict>) .

All authors must disclose any financial and personal relationships with other people or organizations that could inappropriately influence (bias) their work. It is the sole responsibility of authors to disclose any affiliation with any organization with a financial interest, direct or indirect, in the subject matter or materials discussed in the manuscript (such as consultancies, employment, paid expert testimony, honoraria, speakers bureaus, retainers, stock options or ownership, patents or patent applications or travel grants) that may affect the conduct or reporting of the work submitted. All sources of funding for research are to be explicitly stated. If uncertain as to what might be considered a potential conflict of interest, authors should err on the side of full disclosure.

All submissions to the journal must include full disclosure of all relationships that could be viewed as presenting a potential conflict of interest. If there are no conflicts of interest, authors should state that there are none. This must be stated at the point of submission (within the manuscript after the main text under a subheading "Declaration of interest" and where available within the appropriate field on the journal's Manuscript Central site). This may be made available to reviewers and will appear in the published article at the discretion of the Editors or Publisher.

If no conflict is declared, the following statement will be attached to all articles: Declaration of interest: The authors report no conflicts of interest. The authors alone are responsible for the content and writing of the paper.

The intent of this policy is not to prevent authors with these relationships from publishing work, but rather to adopt transparency such that readers can make objective judgments on conclusions drawn.

References

Prepare reference list in accordance with the APA Publication Manual, 6th ed.

Tables and Figures: Tables and figures should not be embedded in the text, but should be included as separate sheets or files. A short descriptive title should appear above each table with a clear legend and any footnotes suitably identified below. All units must be included. Figures should be completely labelled, taking into account necessary size reduction.

Captions should be typed, double-spaced, on a separate sheet. All original figures should be clearly marked with the number, author's name, and top edge indicated.

Illustrations: Illustrations submitted (line drawings, halftones, photos, photomicrographs, etc.) should be clean originals or digital files. Digital files are recommended for highest quality reproduction and should follow these guidelines:

300 dpi or higher

sized to fit on journal page

EPS, TIFF, or PSD format only

submitted as separate files, not embedded in text files.

Color Reproduction: Color art will be reproduced in color in the online publication at no additional cost to the author. Color illustrations will also be considered for print publication; however, the author will be required to bear the full cost involved in color art reproduction. Please note that color reprints can only be ordered if print reproduction costs are paid. Print Rates: \$900 for the first page of color; \$450 per page for the next three pages of color. A custom quote will be provided for articles with more than four pages of color. Art not supplied at a minimum of 300 dpi will not be considered for print.

Page Proofs: All proofs must be corrected and returned to the publisher within 48 hours of receipt. If the manuscript is not returned within the allotted time, the editor will proofread the article and it will be printed per the editor's instruction. Only correction of typographical errors is permitted.

Complimentary Policy and Reprints: Authors for whom we receive a valid email address will be provided an opportunity to purchase reprints of individual articles, or copies of the complete print issue. These authors will also be given complimentary access to their final article on *Taylor & Francis Online*.

Open Access: Articles are eligible for Open Access. Electing this option allows the article to be made freely available online under a Creative Commons License. Authors of accepted papers will have the opportunity to purchase open access at

proofs stage. Please note: This option is separate from Taylor and Francis's NIH Fund policy.

***Email confirmation that the empirical paper was deemed suitable for this journal and confirmation of the word limit. Received on 21st April, 2016:**

Dear Ms. Power:

We would be happy to receive this paper and send it out for peer review.

When you are ready to submit, go to <http://mc.manuscriptcentral.com/umhn>, enter Author Center and follow directions.

We do not have a word limit.

Best always,

Sandra P. Thomas, PhD, RN, FAAN


Editor, IMHN


Appendix D: Poster Advertisement

Coventry University
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Telephone 024 7688 8328
Fax 024 7688 8702

Programme Director
Doctorate Course in Clinical Psychology
Dr Eve Knight
BSc Clin.Psy.D. CPsychol

THE UNIVERSITY OF
WARWICK


Coventry
University



Registered Nurses' Experiences of Violence whilst working on Adult Mental Health Acute Inpatient Facilities in the UK

- ❖ My name is Kathryn Power and I am a Trainee Clinical Psychologist at Coventry and Warwick Universities.
- ❖ My experience as a healthcare assistant working in inpatient settings really gave me an insight into working with those who present with complex difficulties and with those who display violence in these settings.
- ❖ I developed an interest in this area and decided to focus my doctoral research project on exploring registered nurses' experiences of this violence in adult mental health acute facilities in order to gain a fuller understanding.
- ❖ I am asking you if you are interested in being part of this study.
- ❖ This would involve being interviewed by myself on an informal 1:1 basis for about an hour at your place of work.
- ❖ The findings will be used to contribute to current research and to inform practice.
- ❖ More information will be placed in your individual drawers in the nursing office; if you wish to take part you can email Kathryn: powerk2@uni.coventry.ac.uk ☺

*How do **you** experience it?*

Dean of Faculty of Health and Life Sciences
Professor Guy Daly Coventry University Priory Street Coventry CV1 5FB Tel 024 7679 5805

Head of Department of Psychology
Professor James Tresilian BSc PhD University of Warwick Coventry CV4 7AL Tel 024 7657 3009

www.coventry.ac.uk

Appendix E

Participant Information Sheet

Coventry University
Priory Street, Coventry CV1 5FB
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Fax 024 7688 8702

Programme Director
Doctorate Course in Clinical Psychology
Dr Eve Knight
BSc Clin.Psy.D. CPsychol



Participant Information Sheet

Study Title: Registered nurses' experiences of violence whilst working on adult mental health acute inpatient facilities in the UK.

Principal Researcher: Kathryn Power, Trainee Clinical Psychologist
Coventry & Warwick Universities, Doctorate Program in Clinical Psychology

I would like to invite you to take part in a research study. Before you decide it is important that you understand why I am doing the research and what it will involve. Please read the following information carefully and contact myself, Kathryn Power, if you have any questions or concerns.

What is the study about?

The aim of the study is to explore registered nurses' experiences of violence perpetrated by patients on adult mental health acute inpatient facilities in the UK. I make no assumptions about what forms of violence you may have experienced whilst working on adult mental health acute inpatient wards, nor have I made any assumptions about what these experiences were like for you. I would like to discuss your experiences from your point of view. It is hoped that the results of the study will help mental health services to have a better understanding of the issues that are important to nurses when experiencing violence on adult mental health acute inpatient facilities in the UK.

Why have I been invited to take part?

I am looking to interview registered nurses who have worked on an adult mental health acute inpatient ward in the UK and who have experienced some form of violence from patients whilst working on these wards. You have been asked to take part because I am interested in finding out about your personal experiences. I am doing this research because there are very few in-depth studies that look directly at nurses' personal experience of violence whilst working on acute wards.

What will happen if I agree to take part?

If you wish to take part, email myself (Kathryn Power) on the contact details provided below in order to express your interest. I will then contact you to arrange an interview at a time that suits you. This interview will take place in a quiet room at your place of work. I will describe the study and go through the information sheet with you. If you still agree to take part, you will also be asked to give me your signed consent form. By signing the consent form, you will be declaring that you agree to take part in the study and to have the interview audio recorded. You will be given a copy of the consent form to keep. If you decide to take part, you are still free to stop at any time without giving a reason. Your decision to participate or not in the study will have no impact on your employment in any way. The interview will last for about an hour and will be like a conversation. During the interview you will be asked questions about your own experience of violence from patients while working on the wards. You do not need to answer any questions you don't want to.

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Professor Guy Daly Coventry University Priory Street Coventry CV1 5FB Tel 024 7679 5805

Head of Department of Psychology
Professor James Tresilian BSc PhD University of Warwick Coventry CV4 7AL Tel 024 7657 3009

What are the possible disadvantages or risks of taking part?

You may be asked to answer questions about your personal views and experiences which may be linked to potentially difficult situations involving violence on wards that you have experienced. The interview may involve discussing sensitive issues which you may find upsetting. If you do feel distressed, you will be directed towards support and a decision to terminate the interview can be made. You may be encouraged to speak to your line manager or supervisor to gain support. One support service is the NHS staff support system called COPE; COPE provides a confidential counselling service to offer support for staff who have experienced work or personal difficulties (Call: 07920 581981 or Email: COPE@covwarkpt.nhs.uk)

What are the possible benefits of taking part?

You may find the interview interesting as it will provide you with the opportunity to express your experiences and share your point of view. You will also be contributing towards an important piece of research which aims to help understand nurses' experiences of violence in adult mental health acute inpatient facilities in the UK.

Will my taking part in the study be kept confidential?

This study is being carried out by Coventry and Warwick Universities. All information you provide will be kept confidential. Your name will not appear on any information so that you cannot be recognised. Information and your audio recording will be stored in a locked cabinet in a locked office, accessed only by the researcher. The consent form will be filed separately from all other information. Electronic information (such as your interview transcript) will be stored anonymously on a password protected computer known only by the researcher. Audio recordings will be transcribed and then deleted when the study is complete. Transcripts will be kept securely by Coventry University for five years. I must however inform you that if you disclose information that may result in or has resulted in you or anyone else being put at risk of serious harm I may have to inform the appropriate persons and authorities.

What if I decide to withdraw after the interview has taken place?

You are free to leave the study at any time. If you decide to leave after an interview has taken place, all recordings and transcripts of your interview will be destroyed. You will have up to 2 weeks after the interview to withdraw from the study.

What would happen after the interview?

I will label the interview with a pseudonym and type out everything you said in the interview. Recordings of interviews will be deleted once the study is complete. I will send you a copy of the interview transcript if you would like to read it, and if you think there is anything you would like to change or add then you can let me know. I can remove any section that you do not want me to use.

What will happen when the study finishes?

I will send you a summary of the findings by email. The results from all the interviews will be presented in the thesis for my doctorate degree in clinical psychology. The results will also be presented at conferences and in academic publications. Some of your words will be used in quotations and a section of your transcript may be included, but it will not be possible to identify you personally in any reports or articles published.

Who has reviewed and ethically approved the study?

This study has been reviewed and ethically approved by the Coventry University Ethics Committee (ID - P35893) and your NHS Partnership Trust Research and Development Group (ID - CWPT230915A).

Contact for further information

I hope that this information sheet has told you what you need to know before you decide whether or not to take part. If you have any questions at all about the study please contact Kathryn Power on the contact details below.

Thank you very much for reading this information sheet.

Principal Researcher

Kathryn Power

Principle Researcher and Trainee Clinical Psychologist,
Doctorate in Clinical Psychology,
Faculty of Health and Life Sciences,
Coventry University,
James Starley Building,
Coventry,
CV1 5FB,
Email: powerk2@uni.coventry.ac.uk
Telephone: 07990970945.

Kathryn's Research Supervisors

Matthew Wilcockson

Supervisor and Psychological Therapist,
Inpatient care,
Caludon Centre,
Warwickshire,
CV34 5QW
Email: Matthew.Wilcockson@covwarkpt.nhs.uk.

Anthony Colombo,
Lead Academic supervisor and Senior Research Lecturer,
Doctorate in Clinical Psychology,
Faculty of Health and Life Sciences,
Coventry University,
James Starley Building,
Coventry,
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Email: hsx412@coventry.ac.uk.

Helen Liebling,
Academic Supervisor and Senior Lecturer,
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Appendix F

Consent Form

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Programme Director
Doctorate Course in Clinical Psychology
Dr Eve Knight
BSc Clin.Psy.D. CPsychol

THE UNIVERSITY OF
WARWICK



CONSENT FORM

Study Title

Registered nurses' experiences of violence whilst working on adult mental health acute inpatient facilities in the UK.

A study by: Kathryn Power

Coventry & Warwick Universities, Doctorate Program in Clinical Psychology

Please read each of the following statements and initial in the boxes:

1. I confirm I have read and understood the attached Participant Information Sheet and by signing below I consent to participate in this study.
2. I have had the opportunity to ask questions about this study and I know how to contact the researcher or her supervisors if I need to.
3. I understand that I have the right to withdraw at any time during the study and within two weeks after participating in the interview.
4. I am taking part in this study voluntarily.
5. I agree to the interview being audio recorded and understand that the recording will be kept in a secure place, accessible to the researcher only, and will be destroyed once the study is complete.
6. I understand all transcripts from the interview will be kept confidential and that it will not be possible to identify me from any quotations or sections of transcript used in reports or publications. I understand that transcripts will be kept securely for 5 years at Coventry University.

☐☐☐☐☐☐

Name of Participant

Date

Signature

Name of Researcher

Date

Signature

Dean of Faculty of Health and Life Sciences
Professor Guy Daly Coventry University Priory Street Coventry CV1 5FB Tel 024 7679 5805
Head of Department of Psychology
Professor James Tresilian BSc PhD University of Warwick Coventry CV4 7AL Tel 024 7657 3009

Appendix G

Coventry University Ethical Approval

Received 14th September, 2015

registered nurses' experiences of working with violence in adult acute mental health inpatient facilities in the UK.
P35893

REGISTRY RESEARCH UNIT ETHICS REVIEW FEEDBACK FORM

(Review feedback should be completed within 10 working days)

Name of applicant: Kathryn Power

Faculty/School/Department: [Faculty of Health and Life Sciences] School of Psychological, Social and Behavioural Sciences.....

Research project title: Registered nurses' experiences of working with violence in adult acute mental health inpatient facilities in the UK.

Comments by the reviewer

1. Evaluation of the ethics of the proposal:	
A sound proposal with no ethical concerns.	
2. Evaluation of the participant information sheet and consent form:	
Clear and easy to follow with a good level of information for participants	
3. Recommendation: (Please indicate as appropriate and advise on any conditions. If there are any conditions, the applicant will be required to resubmit his/her application and this will be sent to the same reviewer).	
<input checked="" type="checkbox"/>	Approved - no conditions attached
<input type="checkbox"/>	Approved with minor conditions (no need to re-submit)
<input type="checkbox"/>	Conditional upon the following – please use additional sheets if necessary (please re-submit application)
<input type="checkbox"/>	Rejected for the following reason(s) – please use other side if necessary
<input type="checkbox"/>	Not required

Name of reviewer: Anonymous.....

Date: 14/09/2015.....

Appendix H

Trust Research and Development Approval

Received 8th October, 2015

Coventry and Warwickshire Partnership 
NHS Trust

National Institute for Health Research
Clinical Research Network: West Midlands
Binley Business Park
Harry Weston Road
Coventry
CV3 2TX

08 October 2015

Miss Kathryn Power
Trainee Clinical Psychologist
Coventry and Warwickshire NHS Partnership Trust
Doctorate in Clinical Psychology
James Starley Building
Coventry
CV15FB

Dear Miss Power

Project Title: Registered Nurses' experiences of working with violence in adult mental health acute inpatient facilities in the UK.
R&D Ref: CWPT230915A

I am pleased to inform you that the R&D review of the above project is complete, and NHS permission has been granted for the study at Coventry and Warwickshire Partnership NHS Trust. The details of your study have now been entered onto the Trust's database.

The permission has been granted on the basis described in the application form, protocol and supporting documentation. The documents reviewed were:

Document	Version	Date
Ethics Approval Certificate	-	17.09.15
Protocol	1	16.09.15
Participant Information Sheet	1	16.09.15
Consent Form	1	16.09.15
Interview Schedule	1	16.09.15
Debrief Information	1	16.09.15
Poster Advertisement	1	16.09.15
Proposals to Ward Managers	1	16.09.15
SSI Form	180421/856608/6/458/285631/332971	
R&D Form	180421/849168/14/421	

All research must be managed in accordance with the requirements of the Department of Health's Research Governance Framework (RGF), to ICH-GCP standards (if applicable) and to NHS Trust policies and procedures. Permission is only granted for the activities agreed by the relevant authorities.

All amendments (including changes to the local research team and status of the project) need to be submitted to the REC and the R&D office in accordance with the guidance in IRAS. Any urgent safety measures required to protect research participants against immediate harm can be implemented immediately. You should notify the R&D Office within the same time frame as any other regulatory bodies.

Appendix I

Semi-Structured Interview Schedule

1. Can you tell me a bit about yourself?

Prompts:

- How long have you been a nurse?
- What made you want to become a nurse?
- How did you come into this job?

2. Can you tell me a bit about your job?

Prompts:

- What does your work involve?
- How would you describe it?
- How would you describe the ward you work on?
- What are the patients like?

3. Can you tell me about your experiences of violence whilst at work?

Prompts:

- What types of violence have you experienced?
- Can you give me an example of what happened?
- What is it like for you when a patient is violent?
- What is your understanding of this violence?
- What do you think about this violence?
- What are your views about this violence?
- What do you think about the patient who is being violent?

4. What is your working day like when a patient has been violent in comparison to when this does not occur?

5. How does violence impact on you, if at all?

Prompts:

-How do you feel when violent incidents occur?

-What emotions/ feelings did you have at the time?

-What was it like to feel this?

-How do you feel now?

-What is this like?

-What is your understanding of these emotions/feelings? / How do you make sense of these feelings?

-How do you feel about the possibility of experiencing, working with and managing future violence at work?

6. How did you manage these feelings?

Prompts:

-How did you manage these feelings at the time of the violence?

-What did you do to help?

-How do you manage the feelings you have now and what do you do to help?

-How do you deal with working routinely on a ward where you may experience violence?

7. What support do you have for dealing with experiences of violence at work?

Prompts:

- What type of training do you think would be helpful?
- How is space created to reflect on what has happened, if at all?

8. How do you experience caring for the patient after they have been violent?

Prompts:

- How do you work with the patient afterwards?
- How does this affect your work, if at all?
- What are your thoughts about working with the patient?
- How do you manage this situation? (working with the perpetrator afterwards).
- What helps you?

9. Before we finish, would you like to mention anything else that you feel is important about your experiences of violence?

Other prompts throughout the interview where necessary:

- What was that like for you?
- What does that mean to you?
- Can you give me a specific example?
- Can you tell me more about that?
- What do you mean by that?
- Is there anything else you would like to tell me about that?

Appendix J

Demographics Questionnaire

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Doctorate Course in Clinical Psychology
Dr Eve Knight
BSc Clin.Psy.D. CPsychol

THE UNIVERSITY OF
WARWICK



Participant Number:...

Information About You

Please could you answer the following questions to enable us to learn more about who is taking part in this study?

1. What age are you?

.....

2. What is your sex? (Please circle).

Female

Male

3. What is your country of birth?

.....

4. What is your ethnicity? (Please circle).

White British

White (other)

White Irish

Black African

Indian

Pakistani

Black Caribbean

Chinese

Black African

Chinese

Mixed

Black (others)

Other (please state):

.....

Dean of Faculty of Health and Life Sciences
Professor Guy Daly Coventry University Priority Street Coventry CV1 5FB Tel 024 7679 5805

Head of Department of Psychology
Professor James Tresilian BSc PhD University of Warwick Coventry CV4 7AL Tel 024 7657 3009

5. How long have you been a registered nurse for?

.....

6. How long have you worked on adult mental health acute inpatient facilities in the UK for?

.....

7. How long have you worked on your current ward for?

.....

8. Have you had any training on working with violence whilst working on adult acute mental health wards? (Please circle)

Yes

No

If yes, please can you list what training you have had:

.....
.....
.....

Appendix K

Debriefing information

Coventry University
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Telephone 024 7688 8328
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Programme Director
Doctorate Course in Clinical Psychology
Dr Eve Knight
BSc Clin.Psy.D. CPsychol



Debrief Information

Study: Registered nurses' experiences of violence whilst working on adult mental health acute inpatient facilities in the UK.

Principal Researcher: Kathryn Power

Thank you for taking the time to talk to me about your experiences of violence at work. I hope that you have found this interview process beneficial. The findings of this study will help mental health services to better understand nurses' experiences of working with this violence.

Queries

If you have any other questions after taking part in this interview, please contact Kathryn Power, by emailing powerk2@uni.coventry.ac.uk.

Withdrawal Procedure

If you wish to withdraw your data from the study, you will have two weeks after your interview to do so and you can email Kathryn to let her know. Your transcript and audio recording will then be deleted.

Support

If you feel that you need additional support following this interview, you could discuss this with your line manager or supervisor. Alternatively, you could contact the Trust service, COPE: COPE provides a confidential counselling service to offer support for staff who have experienced work or personal difficulties (Call: 07920 581981 or Email: COPE@covworkpt.nhs.uk).

What Happens Now?

If you wish to have a copy of your transcript, then you can request this by sending me an email. You can then ask to make any changes or for any parts to be deleted. I will send you a summary of the research findings by email once the study is complete.

Thank again you for taking part.

Dean of Faculty of Health and Life Sciences
Professor Guy Daly Coventry University Priory Street Coventry CV1 5FB Tel 024 7679 5805
Head of Department of Psychology
Professor James Tresilian BSc PhD University of Warwick Coventry CV4 7AL Tel 024 7657 3009

Appendix L

IPA Analysis Procedure

Table 1: IPA analysis procedure (Smith, Flowers & Larkin, 2009).

Reading and re-reading transcripts	<p>Each audio recording was listened to repeatedly and reflections were noted.</p> <p>Each transcript was read and re-read in order to fully immerse in the data and reflections were noted at this point.</p>
Initial note taking	Initial notes and reflections were made on the left hand side of the transcript margin.
Emergent themes	The initial notes and the nurses' narratives were interpreted to form developing themes. These were noted in the right hand margin.
Identifying connections across emergent themes	Similar themes were grouped together in order to represent pivotal aspects of the transcript. Each group was written on a separate piece of paper and in a particular colour to represent it.
Repeating the process for each transcript	The above analysis was repeated for each transcript.
Identifying patterns across transcripts	Each transcript at this stage had a separate piece of paper, with groups of similar themes in particular colours. These pieces of paper were then laid out in front of the researcher in order to look for patterns across the data set. Identified patterns were then organised together on a final pieces of paper. These formed the superordinate themes.
Clarifying superordinate themes	The superordinate themes were checked to ensure that they represented the groups of themes and entire data set. These were illustrated with quotes from all nurses.

Appendix M

Example of Researcher's Coding from two Transcripts

Nurse one

Codings:

132. I: Could you tell me more about that?

133. P: Violence to me, would result in somebody ending up in hospital with

134. injuries that to me is violence but like you say, you could talk to someone

135. else and they might class somebody as somebody...pushing someone, or

136. grabbing them as a violent action, I wouldn't but I think that is because of my

137. personal background I think that is why I have a higher tolerance of what I

138. would class as violence.

139. I: Would you be able to give me an example of when you have experienced.

140. P: Once. Two years ago in June. Erm, but even then, [laughs] I actually didn't

141. feel like, people say I was assaulted but it's a strange one right, [name] my

142. manager said I'm weird because you know like I don't class it as an assault so

143. I think part of it might have been my fault. But the injuries I sustained were

144. bad, they were horrible.

145. I: Yeah, yeah.

146. P: One of the clients was trying to get off the ward and he was a placid man,

147. he...he was very poorly I mean when he came on the ward he was running

148. screaming all over and and jumping on things.

149. I: Yeah, yeah.

150. P: But, he wasn't aggressive, didn't have any history of violence or anything

151. and he was trying to go off the ward. I went to get him and then, and bring

152. him back on the ward.

Themes:

Personal meaning of violence?

Physical Violence

Personal Construct of violence.

Individual meaning of violence

Comparisons.

Responsibility/Accountability?

Mental illness?

Unexpected?

Aggression was not part of him?

Making sense of violence.

Personal Understanding of violence.

Violence is a physical act?

Severity of act defines violence?

Personal background

Self reflection: own personal experiences have shaped the meaning of violence?

Very definite.

Vivid memory.

Different from other people?

Self as different from others.

Views violence very differently.

Not assault if the patient was not responsible?

Severity of injury defines violence.

Unexpected?

Assessing risk?

Aggression

did not define this patient as a person.

Nurse two

Codings:

Themes:

Personal impact of violence:

Psychological effects of violence:

Need to get it out quickly?

Adrenaline as functional - helped him through the day.

Capacity = responsible?

Needling consequences to protect other people - responsibility?

Sudden impact.

Delayed response.

Vivid.

Impact = explosive impact.

Delayed impacts.

Trauma response.

Survival - keep going.

Counts himself lucky?

Needling to be okay.

Lack of control.

Capacity.

Needling consequences to protect others.

Group survival.

Disappointed?

out of his control?

No Capacity = not responsible + consequences don't apply?

honest?

Support team - protective?

158. P: I suppose how it affected me, when I went home that night it sort of hit me in the

159. night, I woke up with a nightmare, she was stabbing me with some scissors [laughs]

160. and I woke up and I sat with my Mrs and I sort of burst into tears... but that was it,

161. I let it go and managed to get it out, but it was only then it hit me, like the following

162. morning, I suppose the adrenaline got me through the day. It was when I woke up in

163. the morning but after that I was fine, I didn't have any flashbacks. I mean, the staff

164. were really good. I spoke to the psychologist on the ward, I went to occy health, I

165. mean they did everything their side if things, I was going on holiday Luckily I didn't

166. get any flashbacks. I mean I tried to pursue it in terms of police because she has had

167. the police before and she has capacity, but unfortunately we couldn't, the police, the

168. doctors deemed later on that she didn't have capacity.

169. I: Right.

170. P: So unfortunately the police couldn't press it further and couldn't press any

171. charges.

172. I: Okay.

173. P: Yeah, it wasn't just for my... not just because of what happened to me but for the

174. protection of other people, it could happen to them.

175. I: Could you tell me a bit more about that?

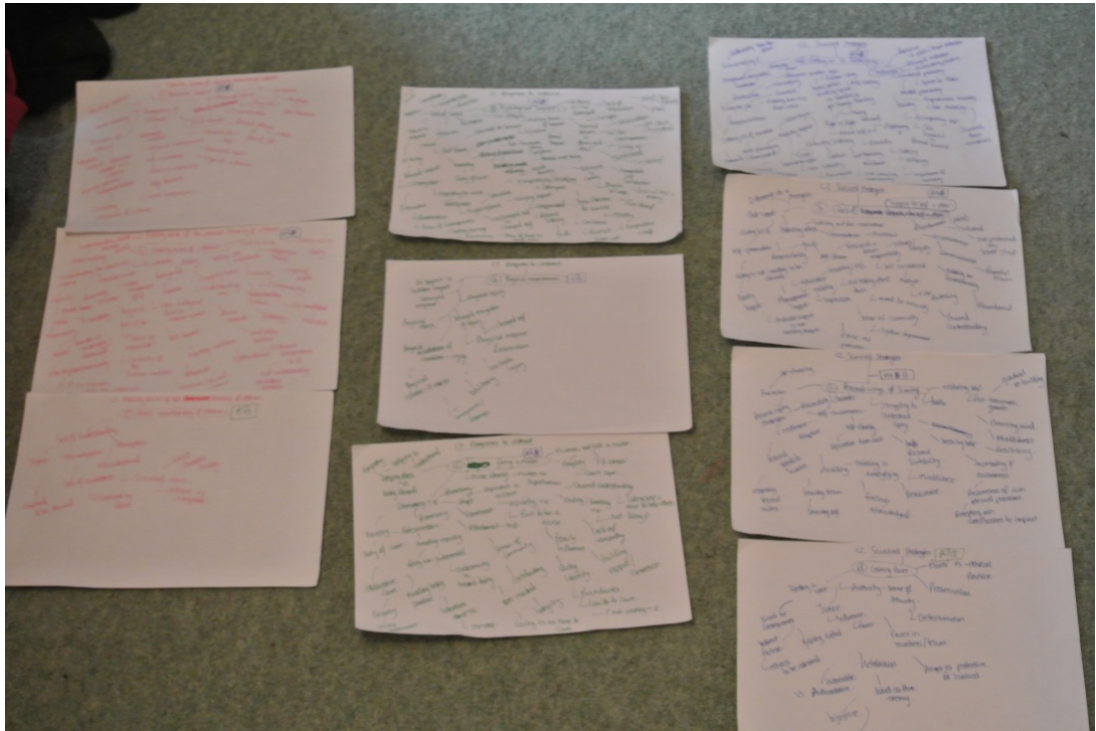
176. P: The process?

Organisation of Themes for Each Transcript



Appendix O

Formulation of Superordinate Themes



Appendix P

Example of Peer's Coding from two Transcripts

Nurse one

132. I: Could you tell me more about that?

133. P: Violence to me, would result in somebody ending up in hospital with

134. injuries that to me is violence but like you say, you could talk to someone—

135. else and they might class somebody as somebody...pushing someone, or

136. grabbing them as a violent action, I wouldn't but I think that is because of my

137. personal background I think that is why I have a higher tolerance of what I

138. would class as violence.

139. I: Would you be able to give me an example of when you have experience...

140. P: Once. Two years ago in June. Erm, but even then, [laughs] I actually didn't

141. feel like, people say I was assaulted but it's a strange one right, [name] my

142. manager said I'm weird because you know like I don't class it as an assault so

143. I think part of it might have been my fault. But the injuries I sustained were

144. bad, they were horrible.

145. I: Yeah, yeah.

146. P: One of the clients was trying to get off the ward and he was a placid man,

147. he...he was very poorly I mean when he came on the ward he was running

148. screaming all over and and jumping on things.

149. I: Yeah, yeah.

150. P: But, he wasn't aggressive, didn't have any history of violence or anything

151. and he was trying to go off the ward. I went to get him and then, and bring

152. him back on the ward.

Physical Violence, Injury.
different meanings of violence.
severity.
personal influence on definition of violence.
Tolerance of violence.
self reflection.
Severe consequences
everybody views violence differently.
reflects that her own background influences how she experiences violence.
She has a high tolerance of violence compared to others.
different from the other nurses?
extreme impact?
Self blame.
type of person.
Who is responsible for violence?
mental illness.
Understanding / making sense of violence.
Trying to work out violence / why violence occurred.
out of control.

Nurse two

158. P: I suppose how it affected me, when I went home that night it sort of hit me in the
159. night, I woke up with a nightmare, she was stabbing me with some scissors [laughs]
160. and I woke up and I sat with my Mrs and I sort of burst into tears...but that was it,
161. I let it go and managed to get it out, but it was only then it hit me, like the following
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166. get any flashbacks. I mean I tried to pursue it in terms of police because she has had
167. the police before and she has capacity, but unfortunately we couldn't, the police, the
168. doctors deemed later on that she didn't have capacity.
169. I: Right.
170. P: So unfortunately the police couldn't press it further and couldn't press any
171. charges.
172. I: Okay.
173. P: Yeah, it wasn't just for my...not just because of what happened to me but for the
174. protection of other people, it could happen to them.
175. I: Could you tell me a bit more about that?
176. P: The process?

Impact of violence.

Sudden.

Psychological

Trauma response.

Psychological effects of violence.

Trying to get rid of impact?

Support from colleagues?

felt control?

Heapside?

tried to act on it.

So she intended to hurt him?

lucky?

lucky escape?

Impact.

Trauma.

Surviving the day.

Has to be okay.

Pressure?

No control?

Needed

Consequences.

Patient Responsibility.

Protecting others.

Needed to

prosecute to

protect others